2003

Patrick O. Barnett v. Salt Lake City Corporation : Brief of Appellee

Utah Supreme Court

Patrick O. Barnett; appellant pro se.
J. Wesley Robinson; attorney for appellee.

IN THE SUPREME COURT OF UTAH

PATRICK O. BARNETT, Plaintiff and Appellant, vs. SALT LAKE CITY CORPORATION, Defendant and Appellee.	)	BRIEF OF APPELLEE Case No. 20030719-SC

APPEAL OF FINAL ORDERS OF THE THIRD DISTRICT COURT OF SALT LAKE COUNTY, STATE OF UTAH, JUDGE STEVEN L. HENRIOD

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PARTIES TO THIS APPEAL

All parties to this appeal are identified in the caption.

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STATEMENT OF JURISDICTION

This Court has statutory jurisdiction over this case pursuant to Utah Code Annotated § 78-2-2(3)(j). However, Appellee Salt Lake City Corporation ("the City") contends below that this Court does not have jurisdiction to consider Appellant's appeal due to his failure to timely file a notice of appeal.

STATEMENT OF THE ISSUES

1. Does this Court have jurisdiction to hear Appellant Barnett's ("Barnett") appeal?

2. If this Court does exercise jurisdiction over this appeal, did the trial court correctly dismiss Barnett's Complaint and deny Barnett's Motion to Reopen?

DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES, ETC.

Utah Code Ann. § 63-30-11(2) provides in pertinent part:

> Any person having a claim for injury against a governmental entity . . . shall file a written notice of claim with the entity before maintaining an action . . .

Utah Code Ann. § 63-30-11(3)(b)(ii)(A) provides in pertinent part:

> (b) The notice of claim shall be:
> (ii) directed and delivered to:
> (A) the city or town recorder, when the claim is against an incorporated city or town . . .

Utah Code Ann. § 63-30-11(4)(a) provides:

> If the claimant is under the age of majority, or mentally incompetent and without a legal guardian at the time the claim arises, the claimant may apply to the court to extend the time for service of notice of claim.

Utah Code Ann. § 63-30-13 provides in pertinent part:

A claim against a political subdivision . . . is barred unless notice of claim is filed with the governing body of the political subdivision according to the requirements of Section 63-30-11 within one year after the claim arises, or before the expiration of any extension of time granted under Section 63-30-11 . . .

Utah Rule of Appellate Procedure 3(a) provides:

(a) Filing appeal from final orders and judgments. An appeal may be taken from a district or juvenile court to the appellate court with jurisdiction over the appeal from all final orders and judgments, except as otherwise provided by law, by filing a notice of appeal with the clerk of the trial court within the time allowed by Rule 4. Failure of an appellant to take any step other than the timely filing of a notice of appeal does not affect the validity of the appeal, but is ground only for such action as the appellate court deems appropriate, which may include dismissal of the appeal or other sanctions short of dismissal, as well as the award of attorney fees.

Utah Rule of Appellate Procedure 4(a) provides in relevant part:

(a) Appeal from final judgment and order. In a case in which an appeal is permitted as a matter of right from the trial court to the appellate court, the notice of appeal required by Rule 3 shall be filed with the clerk of the trial court within 30 days after the date of entry of the judgment or order appealed from. . . .

RELEVANT FACTS

1. On or about May 28, 1971, Barnett was struck by a car in an alley near 971 West 200 North. Barnett brief, Section VII.

2. Barnett has alleged he suffered injuries as a result of the accident. Barnett brief, Section VII.

3. On October 13, 2000, Barnett filed a Complaint in Third District Court alleging that the City's negligence was the proximate cause of his injuries. Complaint ¶ 2, R. 1.

4. On April 30, 2001, the court issued its decision dismissing Barnett's Complaint pursuant to the City's motion to dismiss. R. 134-36.

5. On May 3, 2001, Barnett wrote a personal letter to Judge Henriod, the trial court judge, asking the court to reconsider its decision dismissing the Complaint. R. 137-40.

6. In that letter, Barnett stated: "I suppose my only other course from what the courts tell me is to file a motion of appeal and hope the Supreme Courts [illegible word] help me." R. 138. "I finally understand I have legal rights." R. 139. "I will go to the courts and get a sample paper so I can file for a motion of appeal . . ." R. 140.

7. On May 16, 2003, more than two years after the order dismissing his Complaint, Barnett filed a "Motion to Reopen," asking the court to "reopen" the case based on the same allegations and facts presented in response to the City's motion to dismiss back in 2001. R. 141-45.

8. The City opposed Barnett's Motion to Reopen based on the fact that it was untimely, it did not identify any justification for the lengthy delay, and no new evidence existed that did not exist two years before to justify granting him relief from the judgment. R. 146-48.

9. The trial court granted Barnett an evidentiary hearing on June 23, 2003 to present evidence of his competence, or lack thereof. R. 159-61.

10. Barnett failed to present the court with evidence related to his competence, so the court allowed him an additional 5 days to submit evidence on his behalf to the court.

11. On June 27, 2003, Barnett filed an exhibit of medical records and other documents which contained the following:

a. Medical records from 1971 related to the accident.

b. A personal letter to Judge Henriod.

c. Photos and a plat description of the alley.

d. A copy of the police report of the accident.

e. Prescription list.

f. Various printed materials regarding head injuries.

g. A self-prepared list of "Personal Injuries on Plaintiff as Far Known." [sic]

h. A self-prepared report of leaving a gas station without paying.

i. A Valley Mental Health Psychiatric Evaluation from 12/18/97.

j. Video tape of the alley where the accident occurred.

k. Various non-notarized statements from family members.

(The Record on appeal does not reflect these documents, although they are reflected in the District Court's docket, so they are attached hereto as Exhibit A. The videotape is not included as part of that exhibit, but copies can be made available to the Court upon request).

12. On July 23, 2003, Barnett filed a second exhibit, which consisted of three pages of copied documents, one a document entitled "Evaluation of the Evidence" (page two only, unknown origin), the second a letter from the IRS dated July 15, 2003, and a printout of unknown origin or time period reflecting wages earned. R. 162-64.

13. On August 4, 2003, the trial court issued a signed Minute Entry denying Barnett's Motion to Reopen. R. 165-66.

14. On September 4, 2003, Barnett filed his Notice of Appeal, thirty-one (31) days after the Minute Entry denying Barnett's Motion to Reopen. R. 167-69.

15. Barnett has never filed a Notice of Claim against the City as required by The Utah Governmental Immunity Act, Utah Code Ann. § 63-30-11 and -13.

SUMMARY OF ARGUMENT

Barnett failed to timely appeal the court's decision granting the City's motion to dismiss dated April 30, 2001. He further failed to file his Notice of Appeal within 30 days of the court's decision denying his Motion to Reopen dated August 4, 2003. Barnett filed his notice of appeal of both decisions on September 4, 2004, thirty-one (31) days after entry of the second Minute Order. Therefore, this Court lacks jurisdiction to consider Barnett's appeal.

Even if the Court excuses Barnett's failure to file his appeal in a timely manner, the trial court was correct in granting the City's motion to dismiss and denying Barnett's Motion to Reopen. The documents submitted by Barnett did

not demonstrate sufficient evidence of incompetence to justify tolling the limitations period and setting aside the dismissal. In fact, the documents submitted by Barnett show the opposite. He was married to his first wife for ten years, he has been married to his current wife for over 20 years, he lives with his three step-children and his natural daughter, he has fought for custody of his natural daughter, and he has commenced lengthy litigation against the City on a *pro se* basis before the District Court and the Supreme Court. Barnett admitted in his personal letter to Judge Henriod dated May 3, 2001 that he knew of his appeal rights, but failed to exercise them. The only evidence of disability presented to the court states that he was disabled for Social Security purposes as of May 11, 1998, twenty-seven (27) years after the accident and nearly seventeen (17) years after reaching the age of majority.

Based on Barnett's failure to demonstrate to the trial court that he was mentally incompetent and without a legal guardian for more than 30 years after the accident, the trial court correctly dismissed his Complaint and denied his Motion to Reopen.

ARGUMENT

I.

THIS COURT LACKS JURISDICTION TO HEAR BARNETT'S APPEAL.

The Order dismissing all of Barnett's claims in this case was issued by the trial court on April 30, 2001. The Order was in the form of a signed Minute Entry, it granted the City's Motion to Dismiss, and did not contemplate any further action

by the court or the parties. For purposes of appeal, this Order constitutes the final order or judgment below. Rule 3(a) Utah Rules of Appellate Procedure ("An appeal may be taken from a district or juvenile court to the appellate court with jurisdiction over the appeal from all final orders and judgments . . ."); *See also* Swenson Assocs. Architects, P.C. v. State ex rel. Div. of Facilities Constr., 889 P.2d 415, 417 (Utah 1994). Rule 4(a) of the Utah Rules of Appellate Procedure requires that an appellant's notice of appeal must be filed within 30 days after the date of entry of the judgment or order. Utah Supreme Court case law is clear that "failure to timely perfect an appeal is a jurisdictional failure requiring dismissal of the appeal." Prowswood, Inc. v. Mountain Fuel Supply Co., 676 P.2d 952, 955 (Utah 1984); State v. Bowers, 2002 UT 100.

Barnett appealed the trial court's final ruling more than two years after it was entered. Barnett also failed to file his notice of appeal within 30 days of entry of the trial court's second order or judgment in this case, the Minute Entry ruling entered August 4, 2003. Barnett filed his notice of appeal on September 4, 2004, thirty-one (31) days after entry of the second Minute Order. The plain language of Rule 4 requires that an appellant must file his notice of claim within thirty days of the order or judgment appealed from. This Court has consistently held that a court must follow the plain meaning of a statute or rule, including Rule 4. Salt Lake Child and Family Therapy Clinic, Inc. v. Frederick, 890 P.2d 1017, 1020 (Utah 1995); State v. Parker, 936 P.2d 1118, 1120 (Utah Ct. App. 1997).

Therefore, because Barnett failed to comply with the filing requirements of Rules 3 and 4 of the Utah Rules of Appellate Procedure, this Court lacks jurisdiction to consider his appeal.

II.

EVEN IF THIS COURT EXERCISES JURISDICTION OVER BARNETT'S APPEAL, THE TRIAL COURT CORRECTLY DISMISSED BARNETT'S COMPLAINT AND DENIED HIS MOTION TO REOPEN

A.

Barnett has never complied with the notice requirements of the Utah Governmental Immunity Act

The Utah Governmental Immunity Act ("the Immunity Act") governs the procedure for suing the City and/or its employees. The Immunity Act requires the filing of a notice of claim as a prerequisite to suit. Utah Code Ann. § 63-30-11(2). The notice must be submitted within one year after the claim arises, and must be filed with the City Recorder. Id. at § 63-30-11(3)(b)(ii)(A) and -13. Such notice is required regardless of whether the suit is against the City or its employees. Madsen v. Borthick, 769 P.2d 245, 249-50, 252 (Utah 1988).

Utah law mandates strict compliance with the requirements of the Immunity Act. See, e.g., Greene v. Utah Transit Authority, 2001 UT 109, ¶ 12, 37 P.3d 1156. A claimant must comply with the requirements of the Immunity Act to confer subject matter jurisdiction upon the district court. Id. at ¶ 16. Failure to comply with the Immunity Act's requirements mandates that the district court dismiss the complaint for lack of subject matter jurisdiction. Id.

In this case, Barnett has never filed a notice of claim with the City. Because the filing of a notice of claim is a jurisdictional prerequisite, Barnett's Complaint was properly dismissed by the trial court.

B.

Barnett failed to adequately demonstrate a disability sufficient to excuse him from the requirements of the Immunity Act

Barnett claims he suffered injuries from the accident in 1971 that so disabled him that all pertinent limitations periods should be tolled. Utah Code Ann. § 63-30-11(4)(a) provides that "If the claimant is under the age of majority, or mentally incompetent and without a legal guardian at the time the claim arises, the claimant may apply to the court to extend the time for service of notice of claim."

Utah courts have interpreted the term "mentally incompetent" in the context of this provision to mean "people who are unable to protect their legal rights because of an overall inability to function in society." O'Neal v. Division of Family Services, 821 P.2d 1139, 1142 (Utah 1991) (*quoting* McCarthy v. Volkswagen of Am. Inc., 55 N.Y.2d 543, 450 N.Y.S.2d 457, 435 N.E.2d 1072 (1982)). To qualify for disability protection, courts generally consider a person incompetent for tolling purposes "when the disability is of such a nature to show him [or her] unable to manage his [or her] business affairs or estate, or to comprehend his [or her] legal rights or liabilities." Id., *quoting* 51 Am. Jur. 2d Limitation of Actions § 187 (1970). The O'Neal court focused on a person's

ability to "care for his or her personal safety and provide basic human needs such as food, shelter, and clothing." Id.

Here, Barnett failed to demonstrate such a disability. The only evidence of disability presented to the trial court in opposition to the City's motion to dismiss was Barnett's affidavit (R. 119-122), which detailed the accident, his physical injuries, the fact that he was declared disabled for Social Security purposes since 1998, his difficulty holding jobs, his memory problems, and the events that led to pursuing legal action. Other than medical records from the 1971 accident, Barnett presented no medical documentation of disability, no doctor's opinions regarding incompetency, no evidence that he was unable to comprehend his legal rights, and no evidence that he was incompetent and without a legal guardian for 29 years. The trial court properly dismissed the action.

More than two years later, Barnett asked the court to "reopen" the case. In addition to being untimely, Barnett again failed to present the court with sufficient evidence of incompetence to justify tolling the limitations period and setting aside the dismissal. In fact, the documentation demonstrated the opposite. Barnett's personal letter to Judge Henriod of May 23, 2001 acknowledged that he was fully aware of his appeal rights ("I suppose my only other course from what the courts tell me is to file a motion of appeal and hope the Supreme Courts [illegible word] help me." R. 138. "I finally understand I have legal rights." R. 139. "I will go to the courts and get a sample paper so I can file for a motion of appeal . . ." R. 140.). The documentation of his Social Security disability (Exhibit A) clearly

stated that the disability began May 11, 1998, twenty-seven (27) years after the accident and almost seventeen (17) years after reaching the age of majority.

Significantly, the Valley Mental Health Psychiatric Evaluation of December 18, 1997 (Exhibit A) states that Barnett was married, lived with his three step-children and his natural daughter, and worked for his father in a graphics shop. It detailed stressors of the previous year, including working and fighting for custody of his daughter. It states that he had two other brain injuries after the subject accident that he sustained at ages 16 and 18, both the result of car accidents. He married at age 18 to his first wife of 10 years and has two daughters, one of which lives with him.

Perhaps the most important evidence of Barnett's competence is that fact that he was able to commence litigation against the City on his own, file numerous pleadings in support of his case, take pictures and video of the alley, obtain and submit documents, appear before the district court to argue his case, file an appeal of the court's rulings, and submit an appellate brief to the Supreme Court. These are not the actions of a person who is unable to protect his legal rights because of an overall inability to function in society.

Barnett was not successful in tolling the statute of limitations period due to his failure to demonstrate to the trial court that he was mentally incompetent and without a legal guardian for 29 years after the accident. Based on the lack of sufficient evidence presented by Barnett, the trial court correctly dismissed his Complaint and denied his Motion to Reopen.

CONCLUSION

Based on the foregoing arguments, Defendant/Appellee Salt Lake City Corporation respectfully requests that this Court affirm the trial court's rulings in favor of the City. This Court does not have jurisdiction to consider Barnett's appeal, and even if it does exercise jurisdiction, the trial court properly dismissed Barnett's Complaint and denied his Motion to Reopen.

DATED this 21st day of January, 2004.

J. WESLEY ROBINSON
Senior City Attorney
Attorney for Defendant/Appellee Salt Lake City Corporation

CERTIFICATE OF MAILING

I hereby certify that on the 22nd day of January, 2004, I mailed two true and correct copies of the foregoing, first class postage prepaid, to:

Patrick O. Barnett
3253 South Westjene Circle
West Valley City, UT 84119

EXHIBIT A

CERTIFICATE OF DELIVERY

I hereby certify that i have hand delivered a conforming copy of the forgoing documents,
to the office of J. Wesley Robinson Senior, Salt Lake City Attorney#6321
Attorney for Defendant, Salt Lake City Corporation
451 South State Street, Suite #505 Salt Lake City, Utah 84111
On this date. June 27 2003

Received 6/27/03
J W Robinson

Patrick O. Barnett (Pro Se)
3253 South Westgene Circle
West Valley City, Utah 84119
801-849-1250

Itemized List of Documents submitted to Salt Lake City Corporation and Judge Henriod for June 27th 2003

1. Video Cassett of Mrs. Browns Testimony.
2. Witness' Statements.
3. Prescription List from Alberstsons' pharmacy from 2000 to date.
4. Various Internet facts for Brain Injury.
5. Personal letter to Judge Henriod
6. Valley Mental Health Trancripts.
7. Utah Brain Institute Packet.
8. Letter from Investigator on proff of Gas Station Memory Issue.
9. Case # of discrestionary function exception.
10. Copy of Police Report of Accident.
11. Plat Description.
12. Medical Documents from Primary Childrens Hospital.
13. Personal Injuries On Plaintiff As Far As Known

PRIMARY CHILDREN'S HOSPITAL
DISCHARGE SUMMARY

BARNETT, PATRICK OWEN

ADMITTED: 5-28-71
DISCHARGED: 6-5-71
Hosp. #5-67-60

Staff Phys: E. Dansie, M.D.

Intern: J. M. Andrus, M.D.

HISTORY: This was the first admission for this 7 year-old boy who was brought in by a neighbor who did not witness the accident. The child indicated that he was riding his bike and was struck by a car; the care did not stop. There was left leg pain. The leg was in a cast. He also had a scalp laceration and right shoulder pain.

PHYSICAL EXAMINATION: An acutely ill, severely traumatized boy. BP 110/80. Pulse 50, tachypneic and grunting. There was a left temporal laceration. PERLA. Normal EOM's. Fundi normal. TM's clear. Nose and throat; clear. Neck; full range of motion. There was decreased air exchange but the breath sounds were equal bilaterally. Heart; regular sinus rhythm without murmurs. There was guarding of the abdomen, complained of pain in the left upper quadrant. No bowel sounds. Neurologically the child appeared alert, cooperative, unable to complete remainder of neurologic examination.

LABORATORY DATA: X-rays showed left parieto-occipital fracture, normal cervical and lumbar spine. There was a right proximal humeral epiphyseal fracture. There was a left proximal femoral head fracture, left proximal fibular fracture and left distal tibial fracture. IVP was normal. Flat plate of the abdomen revealed dilated loops of bowel. Spleen was felt to be grossly within normal limits. Chest showed increased infiltrates bilaterally thought to represent traumatized lung. Paracentesis was negative. Admission hematocrit was 37, hemoglobin 12.8. Electrolytes: sodium 131, potassium 4.9, chloride 108, CO_2 16.

HOSPITAL COURSE: The patient was essentially an orthopedic problem. He was taken to surgery where the Jewett nailing of the left hip was done. He was put into traction for his other fractures, casted as necessary. Postoperatively the patient did well. There was no evidence of infection. The child was discharged to be followed by his private physician. Started on Fer-in-sol and given Tabloid #3 for pain.

FINAL DIAGNOSIS: Extensive fractures and orthopedic corrective surgery performed as a result of injuries sustained from an auto accident.

E. M. Dansie, M.D.
Staff Physician

J. M Andrus, M.D.
Intern

JMA:mp
dict. 7-28-71
trans 8-11-71

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah 84103
X-Ray Consultation
Virgil R. Condon, M.D., Radiologist

HOSPITAL 5/28/71
BARNETT, PATRICK
Michael C. Barnett
252 Chicago St.
Salt Lake City, Ut.

Examination Skull, Chest, Abd., IVP, Lt Tibia, Lt. Femur, Rt. Shoulder, C. Spine, T.Sp.
Clinical Problems Hit By Car, Multiple Injuries

9/18/63
Unknown
Unknown
E. Dansie

Requested By. Suchyta/ mp M.D.

X Ray No. 38980 Exam. INTRAVENOUS UROGRAM, A.P. AND LATERAL Date 5/28/71
LEFT LOWER LEG, A.P. LEFT FEMUR, A.P. SUPINE CHEST, A.P. THORACIC SPINE, A.P. AND LATERAL CERVICAL SPINE, A.P. AND LATERAL SKULL, RIGHT SHOULDER.

The preliminary scout abdomen film shows a moderate amount of gas in the stomach and a normal gas pattern in the bowel. There is no evidence of free fluid or air in the abdomen although the gas filled colon is separated from the lateral properitoneal fat line on the left and some local fluid in this area cannot be excluded. Multiple opaque densities several of which represent gravel or stones project over the left abdomen along with three screws apparently in a board on which the patient was resting. There is evidence of a fracture of the left femoral neck with a relative coxa vara position and the distal fragment externally rotated related to the proximal fragment. Pulmonary densities are evident in the left lower lung field. Serial films were made following intravenous injection of contrast medium. There was a good nephrogram effect produced on the left and the left kidney is normal in size and configuration as are the collecting structures. The right kidney is not well defined although is also grossly normal. The contrast medium is extremely dilute presumably related to the fairly rapid infusion of intravenous fluid. A large amount of contrast is visible in the bladder on the 18 minute film and has

WRC

X Ray No: 38980 Exam: CONTINUATION - 2 Date 5/28/71

been subsequently drained on the 30 minute film. On the later abdomen films there is a triangular collection of gas present in the left lateral lower abdomen that suggests it is extra luminal and marginated against the colon on the one film. This was not evident on the first film and may well be iatrogenic related to paracentesis although perforation of bowel would also have to be considered. The liver appears normal in size and shape. The lumbar spine and pelvis show no definite fractures.

IMPRESSION: INTRAVENOUS UROGRAM SHOWING GROSSLY NORMAL RENAL COLLECTING STRUCTURES PARTICULARLY THE LEFT APPEARS NORMAL. THE LIVER'S SIZE AND SHAPE IS NORMAL. THE SPLENIC TIP IS IN NORMAL POSITION ALTHOUGH IT IS SUGGESTED THAT THE WIDTH OF THE SPLEEN IS INCREASED SLIGHTLY RAISING THE QUESTION OF A SUBCAPSULAR HEMATOMA. NO DEFINITE FREE FLUID IN THE ABDOMEN AND ON THE LATER FILM SUGGESTION OF FREE AIR IN THE LEFT LOWER QUADRANT AREA POSSIBLY IATROGENIC. FRACTURED LEFT FEMORAL NECK AS NOTED.

A.P. examination of the thoracic spine and lumbar spine shows no definite abnormalities of the vertebral bodies, pedicles or neural arches as seen on this view..

IMPRESSION: A.P. THORACOLUMBAR SPINE WITHIN NORMAL LIMITS. EXTENSIVE PULMONARY

WRC

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah 84103
X-Ray Consultation
Virgil R. Condon, M.D., Radiologist

X-RAY REPORT

BARNETT, PATRICK

Examination:

Clinical Problems:

Requested By: M.D

X-Ray No.: 38980 Exam.: CONTINUATION - 3 Date: 5/28/71

CONTUSION EVIDENT.

Limited views of the skull were taken because of the patient's fractures and other injuries and a complete skull series would be recommended when the patient's clinical condition will permit. Examination of the skull in the a.p. and lateral projection shows evidence of diastasis of the lambdoidal, occipital mastoid and posterior squamosal suture apparently on the left and a short fracture line extending from the posterior squamosal suture into the parietal bone. There is no evidence of depression and no other significant abnormalities of the skull can be appreciated.

IMPRESSION: POSTERIOR INFERIOR PARIETAL SKULL FRACTURE PROBABLY ON THE LEFT WITH SECONDARY DIASTASIS OF THE ADJACENT SUTURES AS DESCRIBED.

A.P. examination of the left femur demonstrates the fracture of the left femoral neck just above the level of the trochanters. This produces a moderate coxa vara deformity as seen on this examination and there appears to be some external rotation of the distal fragment in relationship to the proximal fragment.

IMPRESSION: FRACTURE LEFT FEMORAL NECK SHOWING NO MAJOR DISPLACEMENT BUT A RELATIVE COXA VARA CONFIGURATION.

Two a.p. films of the chest were obtained one at the beginning of the studies

X-Ray No.: 38980 Exam.: CONTINUATION - 4 Date: 5/28/71

and one just before removal from the department. They show extensive fluffy parenchymal densities along the periphery of the lung field on the left extending throughout the entire length of the chest. There are similar densities peripherally in the right upper chest. These are all fairly characteristic of extensive pulmonary contusion. No pneumothorax or significant hemothorax is evident although there is minimal pleural density along the left lateral chest wall. The heart is normal. No rib fractures can be seen. Bone detail however is not optimal.

IMPRESSION: CHEST FILM SHOWING FAIRLY EXTENSIVE PULMONARY CONTUSION INVOLVING BOTH LUNGS.

Examination of the left lower leg shows a comminuted fracture of the distal tibial diaphysis. There is mild displacement and angulation. There is also a fracture of the proximal fibular diaphysis with minimal displacement and no significant angulation. Moderate soft tissue swelling is present over the distal part of the lower leg. The joint structures are unremarkable.

IMPRESSION: COMMINUTED FRACTURE DISTAL LEFT TIBIA AND A SIMPLE OBLIQUE FRACTURE PROXIMAL LEFT FIBULA BOTH SHOWING ONLY MINIMAL ANGULATION AND DISPLACEMENT.

Lateral [illegible] nominal spine films were obtained and because of the

PRIMARY CHILDREN'S HOSPITAL
SALT LAKE CITY, UTAH

PHYSICIAN'S ORDER SHEET

5/28/71

DATE AND SIGN EACH ORDER

Admit ICU via X-ray
Dx: Car-Ped Accident
Cond: Critical
Diet: NPO
Activity: O
Allergies: O
Nursing: VS q 15 min x 8 pr til stable
then q 1 h tonight & prn
Lab: CBC
U/A
Lytes
C+T 3U WB
Xrays: Skull series
C spine series - cervical LS
IVP
Chest, Kub
Meds: IV R.C./D5 w/dilaudid
Foley Cath to Bed Drain - done
Paracentesis = NS irrigation - done
I x O
Roger F. Sundstrom
5/28
Elec Tamp done
Lytes in AM
Vit c Lyt @ 9 PM & 12 midnite & 3 AM - Tell
Call results to me
Chest x-ray made of all abrasions
Walters / Sundstrom

5 28 71
HARRIETT PATRICK O.
L. CHRISE PVT
9/18/63 0567[illegible]
[illegible]
DATE COST

5 28 71
HARRIETT PATRICK O.
L. CHRISE PVT
9/18/63 0567[illegible]
[illegible]
DATE COST

5 28 71
HARRIETT PATRICK O.
L. CHRISE PVT
9/18/63 0567[illegible]
[illegible]
DATE COST

5 28 71
HARRIETT PATRICK O.
L. CHRISE PVT
9/18/63 0567[illegible]
[illegible]
DATE COST

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

PROGRESS NOTES

Working Diagnosis

DATE	DAILY NOTE MUST BE MADE BY PHYSICIAN IN CHARGE
5/28/71 Under Anes	7 y/o [illegible] with multiple injuries with [illegible] problems to be [illegible] by (1) proximal humerus (2) by (1) [illegible] tibia (3) by (4) tibia & fibula. Closed reduction tibia fibula with [illegible], pin under local. Distal femur [illegible] until surgery is ready to [illegible] pin trip. [illegible] [illegible]
6/29/71 0015	Peds Note Resp rate sl slower - moving air better Abd - early BS, tender to deep palpation & no rebound I & O good
5/29 0020	Surgery notes: (1st seen @ 6:25 PM) 7 y/o W/F struck by car @ 5:30 PM while bicycling. Not known if loss of consciousness. Brought by ambulance to ER where xrays + [illegible] as above, also (R) posterior parietal skull fx, contusions of lungs (R) > (L), gastric dilated stomach & free air on abd. xrays. Lacerations behind (R) ear & posterior (R) parietal scalp cleaned & closed in 4-0 nylon. 1% lido to spin anesthetic. Peritoneal taps done in lower midline & (R) lateral abd & 16 g needle intracath under local anesthetic — no blood obtained from either, despite approx 200 cc lavage & NS. Must observe for subcapsular splenic hematoma, other abd problems—

PATRICK D.
SL PVT
056760
9/18/63

PRIMARY CHILDREN'S HOSPITAL
DISCHARGE SUMMARY

BARNETT, PATRICK OWEN
ADMITTED: 5-28-71
DISCHARGED: 6-5-71
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HISTORY: This was the first admission for this 7 year-old boy who was brought in by a neighbor who did not witness the accident. The child indicated that he was riding his bike and was struck by a car; the care did not stop. There was left leg pain. The leg was in a cast. He also had a scalp laceration and right shoulder pain.

PHYSICAL EXAMINATION: An acutely ill, severely traumatized boy. BP 110/80. Pulse 50, tachypneic and grunting. There was a left temporal laceration. PERLA. Normal EOM's. Fundi normal. TM's clear. Nose and throat; clear. Neck; full range of motion. There was decreased air exchange but the breath sounds were equal bilaterally. Heart; regular sinus rhythm without murmurs. There was guarding of the abdomen, complained of pain in the left upper quadrant. No bowel sounds. Neurologically the child appeared alert, cooperative, unable to complete remainder of neurologic examination.

LABORATORY DATA: X-rays showed left parieto-occipital fracture, normal cervical and lumbar spine. There was a right proximal humeral epiphyseal fracture. There was a left proximal femoral head fracture, left proximal fibular fracture and left distal tibial fracture. IVP was normal. Flat plate of the abdomen revealed dilated loops of bowel. Spleen was felt to be grossly within normal limits. Chest showed increased infiltrates bilaterally thought to represent traumatized lung. Paracentesis was negative. Admission hematocrit was 37, hemoglobin 12.8. Electrolytes: sodium 131, potassium 4.9, chloride 108, CO_2 16.

HOSPITAL COURSE: The patient was essentially an orthopedic problem. He was taken to surgery where the Jewett nailing of the left hip was done. He was put into traction for his other fractures, casted as necessary. Postoperatively the patient did well. There was no evidence of infection. The child was discharged to be followed by his private physician. Started on Fer-in-sol and given Tabloid #3 for pain.

FINAL DIAGNOSIS: Extensive fractures and orthopedic corrective surgery performed as a result of injuries sustained from an auto accident.

E. M. Dansie, M.D.
Staff Physician

J. M Andrus, M.D.
Intern

JMA:mp
dict. 7-28-71
trans 8-11-71

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah 84103
X-Ray Consultation
Virgil R. Condon, M.D., Radiologist

Hospital 5/2[illegible]/71
BARNETT, PATRICK
Michael C. Barnett
252 Chicago St.
Salt Lake City, Ut.

Examination Skull, Chest, Abd., IVP, Lt Tibia, Lt. Femur, Rt. Shoulder...C. Spine, T.Sp.
Clinical Problem: Hit By Car...Multiple Injuries

9/18/63
Unknown
Unknown
E. Dansie

Requested By: Suchyta/ mp M.D.

X Ray No. 38980 Exam INTRAVENOUS UROGRAM, A.P. AND LATERAL Date 5/28/71
LEFT LOWER LEG, A.P. LEFT FEMUR, A.P. SUPINE CHEST,
A.P. THORACIC SPINE, A.P. AND LATERAL CERVICAL SPINE,
A.P. AND LATERAL SKULL, RIGHT SHOULDER.

The preliminary scout abdomen film shows a moderate amount of gas in the stomach and a normal gas pattern in the bowel. There is no evidence of free fluid or air in the abdomen although the gas filled colon is separated from the lateral properitoneal fat line on the left and some local fluid in this area cannot be excluded. Multiple opaque densities several of which represent gravel or stones project over the left abdomen along with three screws apparently in a board on which the patient was resting. There is evidence of a fracture of the left femoral neck with a relative coxa vara position and the distal fragment externally rotated related to the proximal fragment. Pulmonary densities are evident in the left lower lung field. Serial films were made following intravenous injection of contrast medium. There was a good nephrogram effect produced on the left and the left kidney is normal in size and configuration as are the collecting structures. The right kidney is not well defined although is also grossly normal. The contrast medium is extremely dilute presumably related to the fairly rapid infusion of intravenous fluid. A large amount of contrast is visible in the bladder on the 18 minute film and has

X Ray No. 38980 Exam. CONTINUATION - 2 Date 5/28/71

been subsequently drained on the 30 minute film. On the later abdomen films there is a triangular collection of gas present in the left lateral lower abdomen that suggests it is extra luminal and marginated against the colon on the one film. This was not evident on the first film and may well be iatrogenic related to paracentesis although perforation of bowel would also have to be considered. The liver appears normal in size and shape. The lumbar spine and pelvis show no definite fractures.

IMPRESSION: INTRAVENOUS UROGRAM SHOWING GROSSLY NORMAL RENAL COLLECTING STRUCTURES PARTICULARLY THE LEFT APPEARS NORMAL. THE LIVER'S SIZE AND SHAPE IS NORMAL. THE SPLENIC TIP IS IN NORMAL POSITION ALTHOUGH IT IS SUGGESTED THAT THE WIDTH OF THE SPLEEN IS INCREASED SLIGHTLY RAISING THE QUESTION OF A SUBCAPSULAR HEMATOMA. NO DEFINITE FREE FLUID IN THE ABDOMEN AND ON THE LATER FILM SUGGESTION OF FREE AIR IN THE LEFT LOWER QUADRANT AREA POSSIBLY IATROGENIC. FRACTURED LEFT FEMORAL NECK AS NOTED.

A.P. examination of the thoracic spine and lumbar spine shows no definite abnormalities of the vertebral bodies, pedicles or neural arches as seen on this view..

IMPRESSION: A.P. THORACOLUMBAR SPINE WITHIN NORMAL LIMITS. EXTENSIVE PULMONARY

PRIMARY CHILDREN'S HOSPITAL

Salt Lake City, Utah

X-RAY REPORTS

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah 84103
X-Ray Consultation
Virgil R. Condon, M.D., Radiologist

BARNETT, PATRICK

Examination

Clinical Problems:

Requested By M.D.

X Ray No. 38980 Exam CONTINUATION - 5 Date 5/28/71

patient's position on the immobilization board the lower cervical area is not well seen on the lateral film and the upper cervical area not optimally seen on the a.p. view. These two projections however show no definite abnormality in alignment or structure of the vertebral bodies or posterior neural arches.
IMPRESSION: LIMITED VIEWS OF THE CERVICAL SPINE SHOWING NO DEFINITE ABNORMALITY.
On the initial a.p. film of the shoulder in 90 degrees abduction there is an unusual appearance of the superior portion of the metaphysis probably at the bicipital groove but raising the question of a small avulsion type fracture fragment. A second film was made in internal rotation and no discrete fracture visible. The humeral head position appears normal. No definite dislocation or soft tissue swelling is evident. Again, when the patient's condition will permit additional more conventional views of the shoulder are suggested.
IMPRESSION: RIGHT SHOULDER SHOWING NO DEFINITE FRACTURE ALTHOUGH AN UNUSUAL APPEARANCE OF THE PROXIMAL HUMERAL METAPHYSIS IN THE AREA OF THE BICIPITAL GROOVE WAS NOTED.

VRC:mc 60.460

Virgil R. Condon, M.D.
Radiologist

V

PRIMARY CHILDRENS HOSPITAL
SALT LAKE CITY, UTAH
ADMITTANCE RECORD

FAMILY NAME / FIRST NAME / MIDDLE NAME	ROOM	FROM CLERK	NEW CASE / RE-ENTRY / TRANSFER	HOSPITAL NO.	
[illegible]	[illegible]	[illegible]		No 05-67-60	
ADDRESS		HOME PHONE	LOCAL PHONE		
[illegible]		[illegible]	[illegible]		
AGE / BIRTH DATE / SEX / RACE		RELIGION	MARK FOR PERMISH	RE-ENT / NO / DATE / U.P.D. / YES / SERVICE	
[illegible]		[illegible]	[illegible]		
PHYSICIAN / PRIVATE / PRIMARY		REFERRING DOCTOR		ADDRESS	
[illegible]		[illegible]			
PARENTS OR GUARDIAN		PARTY RESPONSIBLE		OCCUPATION	
[illegible]		[illegible]		[illegible]	
ADMISSION DATE / TIME AM PM	DISCHARGE DATE / TIME AM PM			EMPLOYER	
5-29-71	6:11PM	6-5-71	9:30 AM	ROSS JURLEY AVENTISIN	
HOSPITAL INSURANCE NO / YES	INSURANCE CO NAME / ADDRESS			GROUP NO	CONTRACT NO
	BLUE CROSS			05010	320-48 037
ACCIDENT NO / YES	DATE	DESCRIPTION			
XX	5/29/71	AUTO ACCIDENT		AUT. 5:30 PM	
MANNER RECEIVED	ALTERNATE RELATIVE OR FRIEND			ADDRESS	
AMBULANCE	[illegible]			[illegible]	

PROVISIONAL DIAGNOSIS [illegible] MVA.

FINAL DIAGNOSIS	CODE NUMBER
1. Multiple Fractures	829.0 ✓
2. Pulmonary Contusion	861.2 ✓
3.	959.09 ✓
4.	873.42 ✓
5.	

SECONDARY DIAGNOSIS

1.

2.

3.

COMPLICATIONS NO ✓ YES ☐

INFECTION NO ✓ YES ☐ WOUND SYSTEMIC OTHER

CULTURE TAKEN NO ✓ YES ☐ ORGANISM

ISOLATION NO ✓ YES ☐

DATE	OPERATIONS	
6/2/71	Jaw Wiring [illegible]	524.0 ✓

CONSULTANTS Dr G.D Grant MD

TRANSFER TO DOCTOR DATE

CAUSE OF DEATH (INDICATE IMMEDIATE CAUSE AND TO WHAT IT IS DUE) AUTOPSY PERFORMED YES ☐ NO ☐

SIGNATURE OF HOUSE STAFF [illegible] M D

SIGNATURE OF ATTENDING PHYSICIAN [illegible] M D

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah 84103
X-Ray Consultation
Virgil R. Condon, M.D., Radiologist

X-RAY No. 38280

PARNETT, PATRICK

Examination

Clinical Problems

Requested By: M.D.

X Ray No 38280 Exam CONTINUATION - 3 Date 5/28/71

CONTUSION EVIDENT.

Limited views of the skull were taken because of the patient's fractures and other injuries and a complete skull series would be recommended when the patient's clinical condition will permit. Examination of the skull in the a.p. and lateral projection shows evidence of diastasis of the lambdoidal, occipital mastoid and posterior squamosal suture apparently on the left and a short fracture line extending from the posterior squamosal suture into the parietal bone. There is no evidence of depression and no other significant abnormalities of the skull can be appreciated.

IMPRESSION: POSTERIOR INFERIOR PARIETAL SKULL FRACTURE PROBABLY ON THE LEFT WITH SECONDARY DIASTASIS OF THE ADJACENT SUTURES AS DESCRIBED.

A.P. examination of the left femur demonstrates the fracture of the left femoral neck just above the level of the trochanters. This produces a moderate coxa vara deformity as seen on this examination and there appears to be some external rotation of the distal fragment in relationship to the proximal fragment.

IMPRESSION: FRACTURE LEFT FEMORAL NECK SHOWING NO MAJOR DISPLACEMENT BUT A RELATIVE COXA VARA CONFIGURATION.

Two a.p. films of the chest were obtained one at the beginning of the studies

X Ray No 38280 Exam CONTINUATION - 4 Date 5/28/71

and one just before removal from the department. They show extensive fluffy parenchymal densities along the periphery of the lung field on the left extending throughout the entire length of the chest. There are similar densities peripherally in the right upper chest. These are all fairly characteristic of extensive pulmonary contusion. No pneumothorax or significant hemothorax is evident although there is minimal pleural density along the left lateral chest wall. The heart is normal. No rib fractures can be seen. Bone detail however is not optimal.

IMPRESSION: CHEST FILM SHOWING FAIRLY EXTENSIVE PULMONARY CONTUSION INVOLVING BOTH LUNGS.

Examination of the left lower leg shows a comminuted fracture of the distal tibial diaphysis. There is mild displacement and angulation. There is also a fracture of the proximal fibular diaphysis with minimal displacement and no significant angulation. Moderate soft tissue swelling is present over the distal part of the lower leg. The joint structures are unremarkable.

IMPRESSION: COMMINUTED FRACTURE DISTAL LEFT TIBIA AND A SIMPLE OBLIQUE FRACTURE PROXIMAL LEFT FIBULA BOTH SHOWING ONLY MINIMAL ANGULATION AND DISPLACEMENT.

[illegible] films were obtained and because of the

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

NURSES' BEDSIDE NOTES

LEGEND: Routine—R; Mouth Care—O; Bed Bath—Bb; Partial Bath—Pb; Tub Bath—Tb; Complete Rub—Cr; Back Rub—Br; Morning Care—Mc; Evening Care—Ec

DATE	HOUR	
5-28-71	10[00]	7yr old white male admitted - Abrasions noted L hand, L knee, L knee. Cast on L leg. Pt alert - clothing removed. P bathed (bath quiet)
	10[30]	P 120 R. 60 B/P. 110/60 T. 98.6. Pt placed in traction - before bath given. Pt wants a drink - IV running well. Intake 450cc Output 200cc (K Bateman R.N.)
	12[00]	V/S stable. Pt cries & calls for parents. Pupils equal & react to stimuli. Mouth swabbed & dry.
	1[00]	Tube clear to D.T. Urine color - tea to (2) liq. Urine bottle last empty. abd. (2) to Bath soft. Dsg & legs noted to drainage on (2) side of L ankle & calcaneus. skin W/D
	2[30]	Has slept. Slight muscle twitches in (2) leg & ankle. Pt calls to (2) leg. V/S stable T-99
	5[00]	Tube removed & D.T. Pt ate well. Takes all fluids. Ex urine 600 cc -
Last entry	7[30]	Pt awake & alert. Voices to stay to bed -
	8[00]	Watching T.V. & drinking fluids in sips at intervals. Face clean, dry & warm, skin W/D, Pt cheerful. Total out (with 2 Occ. void & stool out) 1200 cc. Intake 1000 cc. (Mary Wood)
	8[00]	V/S T-100 P-88 R-26 BP 110/60. Explained C&R Cast to patient. Offered analgesic for pain. Also explained cables. Taught neurovascular check (cold to touch, discoloration, pain) approved. Started T.V.
	9[00]	Parents at Bedside. Abrasions washed & ointment on. Pain in L leg - Pt. settled.
	10[24]	Waiting transfer. Vital signs stable. Pt resting (no transfer).
	10[24]	Transferred to 4 South (N. Tower) Mary
	11[00] - 12[00]	Resting. parents at Bedside. Playing -
	12[00] - P.M.	Takes only small sips of fluids. Sat up - very small amt. of what Ordered Food rec. trim) at 11[30].

Identification: [illegible] 05 6760

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

NURSES' BEDSIDE NOTES

LEGEND: Routine—R; Mouth Care—O; Bed Bath—Bb; Partial Bath—Pb; Tub Bath—Tb; Complete Rub—Cr; Back Rub—Br; Morning Care—Mc; Evening Care—Ec

DATE	HOUR	
5-29-71	2[00] 3[00]	Sleeps at intervals. Appears to be talking in sleep. Takes only small sips clear fluids. No vomiting noted. Total Parenteral 85cc Output bags 240cc no void (R. Reed LPN)
	3[30]-5[10]	Resting quietly - jumps at intervals - seems to be having nightmares - V.S. √ Parents at bedside. Fussed when BP √
	5[10]-6[50]	Vomited approx 90cc undigested lunch meat and clear fluid. washed - appears to feel better - drank 120cc clear chix broth - tolerated well - sleeping.
	7[15]-9[00]	Awake - V.S. √ - partial sponge bath given & Chlorhex - lotion rub to back - drank 150cc 7up. Few sips at intervals. Dozing - calling for Father Freq. - talks incoherently at times. V.S. remain stable - pupils react.
	9-11[00]	Father at bedside - took few sips H2O. Roused at ate popsicle - coherent awhile then back to freq. incoherent talking in sleep. T - 315cc output cath 230cc A fairly good night. (R. Reed LPN)
	12[00]	Awake, rambling, changes subject of conversation halfway through what was said before. Crying restless, ice bag changed. IV running well. Pupils equal & reactive.
	2-4	Appears to be sleeping, talking loudly, shouting, crying out. Word salad, moving about in bed while talking, but eyes closed.
	6[00]	Activity the same as above.
	7[30]-8[00]	

Identification: [illegible] 8/63 056760 5-28 71

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

NURSES' BEDSIDE NOTES

LEGEND: Routine—R | Bed Bath—~~Bb~~ | Tub Bath—Tb | Back Rub—Br | Morning Care—Mc
Mouth Care—O | Partial Bath—Pb | Complete Rub—Cr | Evening Care—Ec

DATE	HOUR	
5-30-71	8[cc]-9[cc]	Fed small sip of clear fluids. Seen by M.D.
	9[cc]-12[cc]	Seen by Dr. Lance appears more alert than noted.
	11[30]-1[cc]	Fed & tolerated most of both amt & juice. Visited talked smiles seems more contented.
		U-specimen to lab previously. Ongoing on schedule.
	1[30]-2[30]	Parents visiting. Fed liquids. Ret'd water with T.C. & Tot Pt. oral 270 cc. Output Cath 1.19 cc. Seemed to have improved today & good U.P.N.
	3[30]	Seems to be rambling in his talk but responds when spoken to —
	4[00]	T.P.R. 100°(ax) - 124 - 22 - goes to sleep then awakens and screams —
	5[00]	Seems to be sleeping quietly Parents leave —
	6[00]	Awakened & fighting talking and spitting —
	7[00]	Evening care given Washed and rubbed. Sheep skin under back —
	7[30]	Watching TV. and talking to Parents in a normal conversation.
	9[00]	Seems to be sleeping —
	10[00]	Still sleeping. Intake 405 cc. Output Cath. 1060 cc (Lab Extra)
	12[00]	Appears to be talking in sleep
	2-4	Appears to be sleeping.
	5-6	Appears to be asleep
5/31/71	7[00] A.M.	Appears comfortable.
	8[00] A.M.	V.S. Taken, recorded
	8[30] A.M.	Diet Eaten, fair.
	9[00] A.M.	Bathing Pt.
	9[30] A.M.	Bath Over.
	10[30] A.M.	Dressed Cheerful
	11[30] A.M.	Noted Urin

Identification:

BARNETT, PATI
E. DANISE PV
033798

5 30 71

PRIMARY CHILDRENS HOSPITAL
Salt Lake City, Utah

BARNETT, PATRICK
6/2/71

RECORD OF SURGICAL OPERATION

Medication & Time

Date 6/2/71 T.P.R.

Surgeon

1st Assist.

2nd Assist.

3rd Assist.

1st Nurse

2nd Nurse

Charge Nurse

Pre-Op. Diagnosis

Post-Op. Diagnosis FEMUR

Post-Op. Condition

Complications None

Abbie and Sponge Count

Packs or drains

Operation:
1 Jewett nailing of left hip.
2
3
4
5

Anesthetic Time To

O.R. Time

Anesthetic

Anesthesiologist

Medications in O.R.

Operative Procedure and Findings:

Under general anesthesia, with the patient on the fracture table, the left hip area was prepped with Phisohex, Ioprep and alcohol and the wound was then covered with sterile drapes. The patient's left lower limb was suspended from the fracture table, using a traction bow which was in place in the lower leg cast. X-rays were taken in several positions revealing the position of internal rotation to be the position in which the fracture was best lined up. Following this part of the procedure, a lateral hip incision was made about 4" in length in the skin, subcutaneous tissue and down to the fascia line which was incised. The vastis lateralis was then retracted anteriorly and the fascia near the posterior insertion of the vastis was incised. Blunt dissection was used to obtain exposure of the proximal femur. After the lateral portion of the upper metaphyseal area was exposed the guide pin was placed into the head of the femur, X-ray control being required to obtain a satisfactory pin placement. Next, the reamers were used to ream a hole in the lateral cortex. Again, X-ray control was used in the next step of the procedure to show the position of the Jewett nail. A 2-1/4" Jewett nail was selected and placed over the guide wire and placed into the neck & head of the femur. This required several adjustments during the surgical procedure to get the placement accurate, and this was done under X-ray control. Once the Jewett nail was satisfactorily inserted, additional impaction was performed to close the proximal & distal fragments of the fracture. Final X-ray showed satisfactory alignment and position, after which the Jewett nail was secured to the shaft with 3 screws. The wound was then irrigated with a solution containing Keflin and the fascia lata was closed with 2-0 chromic interrupted suture, the subcutaneous with 3-0 chrome and 3-0 plain, and the skin with a 3-0 subcuticular wire. Blood loss was between 100 & 150 cc; none replaced during the procedure. There were no complications. Sterile dressings were applied, followed by a hip spica cast. Patient was then transferred back to the ICU area for recovery. He did well.

Identification:

Operating Surgeon
Dr. A.J. Groot

PARENTERAL FLUID

I V FLUIDS & MEDICATIONS	TIME START	AMT. ABSORB	TIME DC'ed	NAME
#2 Whole Blood		200cc		
#3 500cc. Isolyte D	D'C	100		
	8 HOUR TOTAL	300cc		
~~#3 Continue 100~~				
	8 HOUR TOTAL			
	8 HOUR TOTAL			

Identification

5-67-60

MARY CHILDREN'S HOSPITAL

Salt Lake City, Utah

27528

EMERGENCY RECORD

NAME: Last	First	Middle	Sex	Race	Religion	Birthdate	Age	P.S. ☐ Pvt. ☑
BARNETT	PATRICK	OWEN	M	C	LDS	9-18-63	7	

Address	City	State	Home Phone	Parents or Guardian
252 Chicago St.	SLC	Utah	NONE	Michael O. Barnett

Employer of Guardian	Insurance Co.	Address of Ins. Co.	Group No.	Contract No.

Place of Accident	Date of Injury	Time	Drug Allergies	Last Tetanus Injection

Informant	House Staff	Attending Physician
	Suskq 6	C

Arrival	Discharge	Disposition
Date 5-28-71 Hour 6:15 A.M. P.M.	Date Hour A.M. P.M.	ICU

Chief Complaint: Hit by car - Multiple injuries B.P. 110/80 T. ____ P. 120 R. ____

History and Physical Findings:

Admit Ped Car Accident

Diagnosis:

Treatment Orders:

Signed M.D.

Nurses' Notes

7½ yo male c upper & multiple injuries admitted to ER for X-rays. BP 110/70 remained stable @ 110/70 100/55 for eight hours. P- 120. Transferred to OR for suturing by Dr. Pritchard. Splint & Cast applied to RLE. Transferred to ICU

5-28-71 — C Gillis RN

Date — Signature of Nurse

Emergency Room			
Drugs			
Supplies and Dressings			
Laboratory			
X-Ray			
Other:			
TOTAL			

CONSENT FOR TREATMENT, ADMINISTRATION OF ANESTHETIC, OPERATION, TAKING OF ANY X-RAYS, RELEASE FROM HOSPITAL

This is to certify that I the undersigned, hereby consent to and authorize the administration and performance of all treatments and operations and the taking of any x-rays which in the judgment of the physician may be considered necessary or advisable. Further, I agree that if the patient's case is handled by a self-insured organization or mutual hospital association, that the Insurance Carrier or Agent is hereby authorized to have access to and make copies of the patient's hospital records. If the patient should leave the hospital without the written consent of the attending physician, I hereby release said physician and the hospital of all responsibility for this action.

Lonnie Christensen — Signature of Witness

Michael O. Barnett — Signature of Parent or Guardian

PRIMARY CHILDREN'S HOSPITAL
SALT LAKE CITY, UTAH

ANESTHESIA RECORD

AGE	WEIGHT	SEX	RISK
7 1/2	57 lbs	F	2

LABORATORY
Hct 37% WBC UA

REMARKS:

1. Mask induction Fluo/N2O/O2
2. IV (R) foot and #21 Butterfly
3. Intubation #3.0 Portex tube, #2 Miller fair fit Clear OK bilat
4. Extubated
5. To PACU

OP. Time: 2'10"
ANES. Time: 3'6"
Summary:
1-A 5%DP/AC 490cc
EBV = 25kg x 70 = 1750cc
EBL = 130cc

AGENTS
Fluo 5 1/2 — 1 1/2 — 1
N2O 2 1/2
O2 3 1/2

BLOOD OUT
IN
EBL = 130

TIME 1400 1700 1800 1830 1900

Start Anes. X
Start Op. ⊙
End Anes. ⊗
Rec. Room R
B. P. V A
Pulse •
Resp. O
Temp. Δ
Tourn. T
Position
Section S

TEMP °C: 40, 38, 36, 34, 32, 30

SYMBOLS

POSITION

PREMEDICATION:
DRUG Valium Scopol Morphine Scop
DOSE 10mg 50mg 5mg 0.4mg
ROUTE PO PO IM
TIME 0845 1325 1515
EFFECT sleepy sleepy
PREOP. DIAG: Hx Right Inguinal

AGENTS TECHNIQUES
A. Fluothane
B. N2O-O2
C.
D.
E.
F.

SCO
EJ

PROPOSED OPERATION
OPERATION: Right Inguinal (L) Hyd
SURGEONS:

BARNETT, PATRICK D.
DANISE PYT
056760

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

PROGRESS NOTES

Working Diagnosis .....

DATE	DAILY NOTE MUST BE MADE BY PHYSICIAN IN CHARGE

Neurol: CN's intact - alert, cooperative
Unable to complete neuro exam

Imp: Auto Ped Accident Victim - multiple injuries

Xray: Skull: ⓡ parietooccipital Fx
Spine: ⓝ cervical & LS
Extr - upper: ⓡ prox humeral epiphyseal Fx
lower: ⓡ prox femoral head Fx
ⓛ prox fibular Fx
ⓛ distal tibia Fx

IVP: ⓝ
Flat abd: dilated loops of bowel
spleen grossly wnl
Chest: ↑ infiltrates bilat

Lacerations: No return, saline infusion → ⓑ no return.

Plan: Set Fx's - admit ICU
Closely watch for splenic Fx

Roger F Dunlavey MD

[illegible]

[illegible] 9/18/63 056760 [illegible]
PATRICK O.
EL. CAPITEL PAT
CS3768

28 - 71

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

PROGRESS NOTES

Working Diagnosis ....

DAILY NOTE MUST BE MADE BY PHYSICIAN IN CHARGE

DATE	
7/29/71	[illegible]
29-71	afebrile awake, alert - VS stable (walking TU) plan: - [illegible] Transfer to 4-S Andrus Abdomen ↓ Bowel sounds but not particularly tender - No peritoneal irritation detected - a little tender in LUQ - Probably free air on abd films [illegible] to [illegible] abdomen [signature]
5/29	[illegible] BT's but no [illegible] since [illegible] ICU. [illegible] clear. Abd not distended, denies abd pain [illegible]. No abd [illegible] or masses palpable, no particular tenderness, no rebound. Lungs sound clear. PERRL, no obvious neuro deficits [signature]
5/30	Temp 101° this AM - will order ASA - is on [illegible]. [illegible] BT's, [illegible] on full liq diet. Abd flat & soft, no masses, no apparent pain or tenderness. Hct = 34%, will ✓ again today. Disorientation ascribed to demerol & valium - D/C'd - but concerned about concussion. PERRL, EOM coordinated, fundi poorly seen, but seem WNL. Minimal to no Ⓡ KJ or AJ. [illegible]

E. LAMISL PAT... PATRICK D.
9/18/63 056760
... 29 71

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

PROGRESS NOTES
History & Physical

Working Diagnosis

DATE	DAILY NOTE MUST BE MADE BY PHYSICIAN IN CHARGE
1/28/71	Resident Admission Note CC - Accident Victim HI: - 1st ER admission for this pt - Brought in by neighbor who did not witness accident - Pt coherent - states he was riding his bicycle & was hit by car - car did not stop - Arrives c/o (L) leg pain - leg in air splint - also has scalp lac + (R) shoulder pain PH } unkn - parent not available FH } PE: Acutely ill, severely traumatized ♂ BP 180/80, pulse 50 - tachycardic, grunting Head: Wrapped in gauze - (L) temporal laceration Eyes: PERRLA, EOM full, fundi (N) Ears: TM's dl injected, bilat light reflex present Nose: no blood Throat: clear Neck: moving actively Chest: shallow resp; not splinting Lungs: ↓ air exchange but CS. equal bilat Heart: RSR S (-) Abd: guarding + c/o pain LUQ; ↓ BS. no masses palpable Gen: C'ized & talks N Extrem: (R) shoulder pain ↓ ROM (L) arm (N) (L) leg in air splint - scrapes ↓ any movement (-) by

PATIENT'S NAME PATRICK
DATE ADMISSION 9/18/63 056760
CLINIC ISL PVT

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

NURSES' BEDSIDE NOTES

LEGEND: Routine—R; Bed Bath—Bb; Tub Bath—Tb; Back Rub—Br; Morning Care—Mc; Mouth Care—O; Partial Bath—Pb; Complete Rub—Cr; Evening Care—Ec

DATE	HOUR	
1/71	11:30	Pt. out of O.R. via gurney in cast. Incision to R. PV
	11:40	Appears to be sleeping. (Mother present)
	11:50	Moving all limbs in cast. Cries when touched.
2-71	12:50 AM	Awake NAD for surgery — Seems to be sleeping
	2:00-10:00 AM	Continues to sleep well — No problems — O.
	6:30 AM	Quiet pre-op night — sleeping well (R. Bontrager RN)
	8 AM	Awake — Voided 200 cc
		Had 120 cc 7 up — mother here
	10:00	Had sponge bath — dressed for surgery — Restless — pretty fussy & crying. Finally fell asleep at 11:30 intermittently — mother left bedside (D. Rasmussen)
	3:00	Ulsenil 5 mg & scopolamine 0.2 mg given IM in (R) thigh
	3:25	D.K.O.
	8:10	Returned to room from OR 4. IV running. Tps = 97.6 16. 24 Lungs Impaired.
	8:30	Awake. 120 cc's H2O. Position to right. Nebulizer running at bedside.
	9:15	Blood I.V. Given — nursing. VS: 128 24.
	9:30	VS: 132. 20. Lungs responsive.
	9:45	VS: 140-20. Appears to be doing well.
	10:00	VS: 136. 20. Taking sips of 7up.
	10:15	VS = 120-20. Voided 230 cc's. Formula 75 cc's Imp.
	10:30	VS = 108. 20 Taking 75 cc's Imp. Appears to be doing well.
	10:45	VS = 120. Lungs. I.V. running (R) arm restrained c arm board.
	11:00	VS: 120-20 Lungs clear. Crying. (Mother present)
3-71	12:00	V.S. taken. Temp. 99.6 P 150 R: Took 120 cc Imp. tolerated well.

Identification
33790
BARNETT, PATRICIA
F. CAUCASIAN
5 31 7.

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

NURSES' BEDSIDE NOTES

LEGEND: Routine—R; Mouth Care—O; Bed Bath—Bb; Partial Bath—Pb; Tub Bath—Tb; Complete Rub—Cr; Back Rub—Br; Morning Care—Mc; Evening Care—Ec

DATE	HOUR	
6-3-71	2[00]	Blood cult in 2 hr. cult. by P.A. Very restless & tries crying out. In Stem. Voided. 22cc in Foley. Is very wet
	4[00]	Sleeping. Still very restless. Urine same quit running. Out of tact.
	5[00]-6[00]	Seems very restless 5[30] P.O. pain med given and seemed to settle down and sleep. Hard-core sudden I.V. apparently infiltrated and discontinued — Dextrose 5%
	8[30]	½ amp Sodium Iodide given I.V. in (R) distal arm - (R) hand
	8[00]	B. taken 98.6 100. Appears uncomfortable. Mouth
	8[30]	clipped foot. Liquids encouraged. Turned on side.
	9[00]	Sleeping at intervals. Still restless.
	11[30]	½ amp Demerol (.25cc) given IM in (R) distal area - Child
	10[00]	(R hand swelling). Ice pack applied.
	11[00]	Turned on back. Color in lips appears good.
	12[00]	B. checked. Crying at intervals. Sounds clearly congested. Added 50cc concentrated urine
	1[00]	Sleeping deeply
	2[30]	Turned onto side. Dressing on back draining. Dressing changed. Sutures
	4	V.S. taken & pt. irritable (Tetrex)
	5:30	Taking liquids fairly well - grandmother at pt's
	6:30	Turned - still crying -
	7:30	ready for bed - Tucked - See Dr. to 6 tonight -
	[illegible]	Barely crying -
	9:30	Iv tight & moist - report about this -
	10:30	awake - still crying - Is settled
4-7-71	12[00]	appears to be sleeping in bed. Pulse, Resp. and B. intervals
	2[00]	Sleeping in bed. Patient [illegible]

Identification: 5317 410 [illegible] 1798 HAMETT, PATRICK DENISE PVT

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

NURSES' BEDSIDE NOTES

LEGEND: Routine—R | Sed Bath—Bb | Tub Bath—Tb | Back Rub—Br | Morning Care—Mc
Mouth Care—O | Partial Bath—Pb | Complete Rub—Cr | Evening Care—Ec

DATE	HOUR	
6-4-71	11[00]	Sleeping. Still restless position changed
	6[00]	Sleeping @ intervals. No apparent problems. Bowel Sig. N. Neg. (H
	8[00]	VS taken. Crying for water. Vocalizing. Cac approx good.
	8[30]	Refused pty care. Taking some liquids.
	9[00]	Bkfast (not eaten)
	10[00]	Up in wheel chair. Ambulating well.
	12[00]	VS taken. Ate some of lunch.
		C/o leg hurting. Ed explained
	1[00]	Back to bed. Turned on abdomen.
	1[30]	Sleeping again.
	2[30]	Turned on abdomen. Sleeping. Rest restless @ intervals. (2 hours)
	5[00] p.m.	Appears comfortable
	4[00] p.m.	Awake. VS taken. @ present. Seems comfortable. No C/O pain. Offered
	5[00] p.m.	Visit. Tablet. Talk. Turned on back
	6[00] p.m.	watching T.V. No C/O pain. Offered.
	7[00] p.m.	Appears comfortable
	8[00] p.m.	Restless. Alert. VS checked.
	9[00] p.m.	Prepared for bed. Asst. to bed. Quiet
	10[00] p.m.	Awake. Visiting w/ Mother. (J. Grant) N. Edu
6-5-71	12[00]	Repositioned with pillows in bed.
	12[30]	Crying and calling for bm matron.
	1[00]	Bleeding on back. Appears to be dried.
	2[00]	Mother is in room. (S. Hatch) B.M.
	4[30]	Awake and crying. States back pain.
	5[00]	Is quiet and resting.
	5[45]	Demerol 25mg given IM in Deltoid for pain in leg. P. Crockett RN.
	7[00]	Appears to be resting comfortably. (S. Hatch B.S.N.)
	8[00]	VS taken. Resting quietly

Identification:

PRIMARY CHILDREN'S HOSPITAL
SALT LAKE CITY, UTAH

PHYSICIAN'S ORDER SHEET

DATE AND SIGN EACH ORDER

Pat Barnett

BARNETT, PATRICK O.
E. DANISE PVT
033798

5 30 71

COST

41

Q
ASA 5 grains PO q 4 hrs PRN temp > 101
Hand + foot restr
Keep legs @ 90°, 60°
- D. Taylor, RN

P May 71
D/cpt U/A from catheter today
Have parents call me today
- J. Dayley RN

5-71 Tabled #3 q P.O. q 4 hrs. P.R.N
dc 2nd U/A to see Tractions
P.O. per Amcot by
to marshall

7/31/71
C/c with left
BKA - CSS x 2 30mm equal to Eng 7102
CSS catch cervine (Done)
P. Crookston RN
-31-71
Chest x ray
√ U/A + C/S before d/c Foley - (Done)
√ U/A 6 hrs after d/c Foley -
P. Crookston
5/31
① U (L) tibia - fibula prosthe
Applied
31-71 AP of hip also
T.O. to Recovery

BARNETT, PATRICK O.
E. DANISE PVT
033798

5 30 71

DATE

COST

41

BARNETT, PATRICK O.
E. DANISE PVT
033798

5 30 71

DATE

41

BARNETT, PATRICK O.
E. DANISE PVT
033798

5 30 71

41

PRIMARY CHILDREN'S HOSPITAL
SALT LAKE CITY, UTAH
PHYSICIAN'S ORDER SHEET

DATE AND SIGN EACH ORDER

5/31/71
D/C I V
Ampicillin 500 mg po q 6h
June RN
Lundy G

5 31 71
BARNETT, PATRICK O.
E. DANISE PVT
5/18/63 056760
033798
410 2

5-31-71
X-rays
. skull series
. chest ap & lat
. ® shoulder
Pict in am
repeat U/A.
S Taylor, Rtl. Andrus

5 31 71
BARNETT, PATRICK O.
E. DANISE PVT
5/18/63 056760
033798
410 2

6-1-71
Hold skull series
TODs Andrus S Taylor, RT.
Andrus.
C. Libbe RT
6-1-71 Clear liquids until 8 45 am
Otherwise NPO midnight
Valium 10 mg PO 8 45 am.
Seconal 50 mg po 11 am

5 31 71
BARNETT, PATRICK O.
E. DANISE PVT
5/18/63 056760
033798
410

Pneumo 5 mg - Dr on call for OR
Scopolamine 0.2 mg
EL

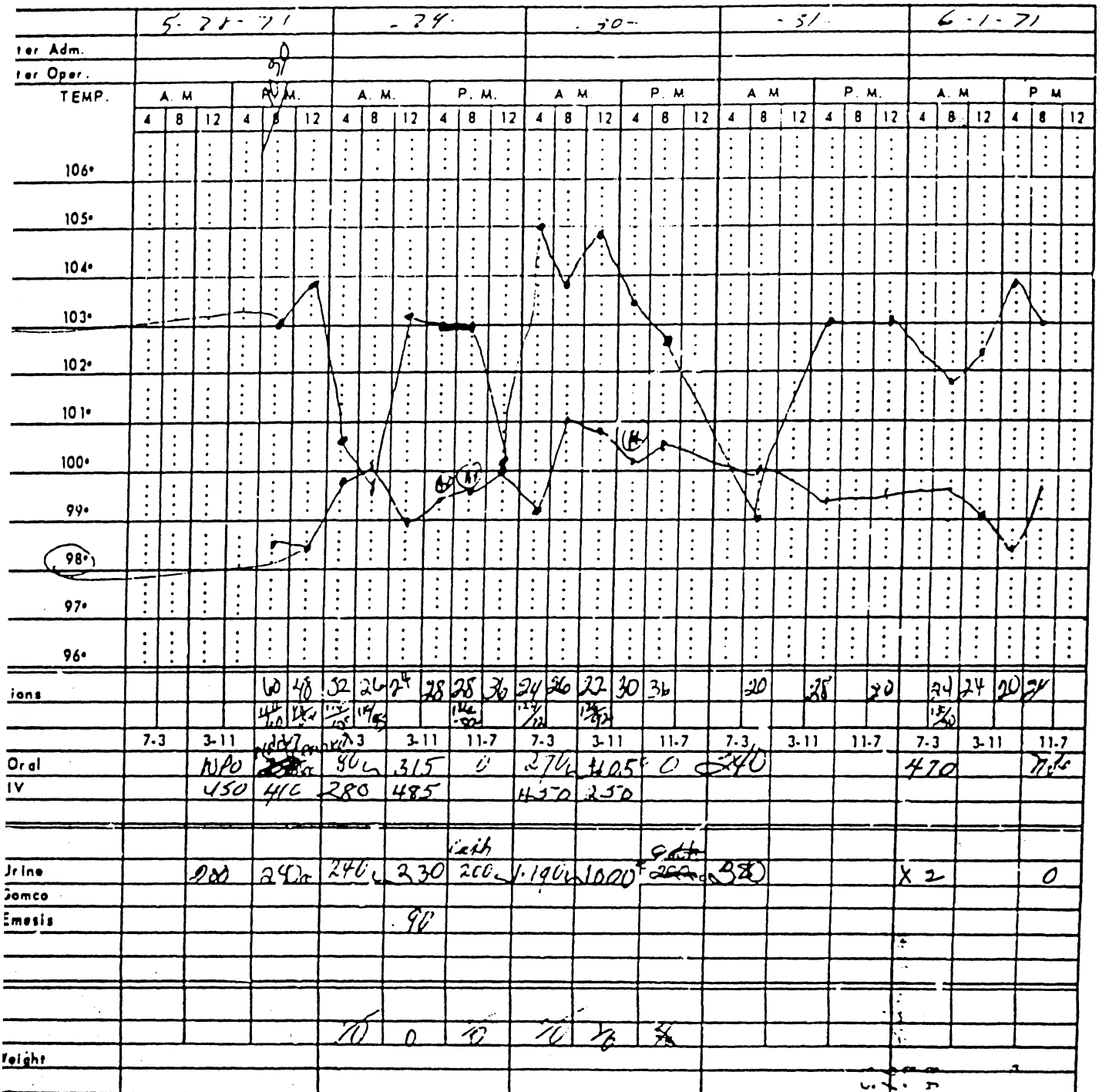
5 31 71
BARNETT, PATRICK
E. DANISE PVT
5/18/63 056760
033798
410

T & C 1 unit w. blood.

[redacted]IMARY CHILDREN'S HOSPITAL

Salt Lake City, Utah 84103

CLINICAL SHEET



IDENTIFICATION:

Medications Date →	5-28 71	-29-	-30-	-31-	6.1.71
Ampicillin 4gm Inj.	4g	8a 4-8	8-12-4-8	8 12 4 8	
D.T. 1.5cc IM		2 PM			
Vancocin 500mg (IV)		10a 2-6p 2-10			
Valium 2mg. P.O		8:30			
Tasseal 2 3/4 PO			4p	12p	
Ampicillin 500mg mpo				8 12 4 8	

IDENTIFICATION

CLINICAL SHEET

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah 84103
X-Ray Consultation
Virgil R. Condon, M.D. Radiologist

6-1-71

Examination: L tibia-fibula portable, AP & Lat

Clinical Problems: Cast adjustment

5 31 71

41025

BARNETT, PATRICK D.
S. SPRISE PVT
033790

Requested By: Alanick JEH M.D.

X Ray No. 38980 Exam: PORTABLE AP & LATERAL LEFT TIBIA & FIBULA Date 6/1/71
AP LEFT HIP

The comminuted fracture of the distal tibial shaft and the oblique fracture of the proximal fibular shaft are again visualized. The extremity is now encased in a plaster cast. The tibial fracture fragments remain in apposition. There is minimal medial displacement of the major distal fragments. No significant angulation is noted. The fibular fracture fragments are in close approximation.

IMPRESSION: POST CASTING FILMS OF THE LEFT LEG SHOWING A COMMINUTED FRACTURE OF THE DISTAL TIBIA AND A SIMPLE OBLIQUE FRACTURE OF THE PROXIMAL FIBULA WITH THE POSITION OF THE FRACTURE FRAGMENTS BEING SATISFACTORY.

A single AP portable film of the left hip again shows the fracture involving the distal portion of the femoral neck. The resulting coxa vara deformity has not changed definitely although accurate comparison is not possible since films localized to the hip region were not obtained. Except for the femoral neck fracture no abnormality is noted.

IMPRESSION: FOLLOW-UP FEMORAL NECK FRACTURE WITHOUT DEFINITE INTERIM CHANGE IN THE POSITION OF THE FRAGMENTS

GWN:mg 0 G. William Nixon, M.D., Radiologist

X Ray No. 38980 Exam: RIGHT SHOULDER Date 6/1/71

Examination of the right shoulder reveals no bone, joint or soft tissue abnormality.

IMPRESSION: RIGHT SHOULDER WITHIN NORMAL LIMITS.

GWN:mg 0

G. William Nixon, M.D.
Virgil R. Condon, MD
Radiologists

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

PROGRESS NOTES

Working Diagnosis

DATE	DAILY NOTE MUST BE MADE BY PHYSICIAN IN CHARGE
7/31/71	Temp 100-101. Abd distended moving all fluids - ? tetanalgesia ? Pseudo Emergency - abd examined. soft, good BS, ? tenderness. - Temp ? plan, rales ? upper allergic bases. Hct 33-34 stable.
1 Aug 71	to get chest film today Remains ill not quite normal breath. Human Pt is oriented, coherent Fundi OK TM's OK.
7/31/71	Taking po diet well Will D/C IV + continue po Ampicillin before we get phlebitis & fever + start closing that wound
1-71	auto accid/Fx · afebrile ; lungs clear RR 20 ; NSR ~HR 110 · 5 complaints / alert + oriented x 3 / ~~splenic~~ liver palp. plan ① repeat x rays ② CBC / UA.
2/1/71	Pre Ares 7 yr. appx 60 lb. w ♂ for ~~valve~~ Recon ② hip. Hx renewed, Chest clear Will check x-ray Hct 39
2-71	plan ortho surg - hip pinning today. Hct 31% last night - ? transfusion

Medications Date→	7-1	7-2	7-3	7-4	7-5
Vistaril 100mg po					
Nembutal 80mg po					
Darvocet 650mg po					
Morphine 3mg IM					
Tylenol 1gr po					

IDENTIFICATION:

PATRICK OWEN
P.V.T.
U.S. 56760

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah

PROGRESS NOTES

Working Diagnosis

DATE	DAILY NOTE MUST BE MADE BY PHYSICIAN IN CHARGE
6/2	Op note. Swoot. A/Neck Mouth mailing Obj No probs. EBL 100-125 cc To ICU ok A/Neck
6/2 1800	Postanesthesia awake. alert. ~~Barat~~ Exchanging air well but voice is a bit stridorous. Should diam ~~Dec~~ cold mist ~~for next~~ prn J Dean
6-3.	General condition satisfy. Complaining pain. No nausea - Pt and mother plan IV infiltration - well -
3 June 71	Lungs clear - Color better - Dan
6-4-71	. Pt feeling - down to 31%
	. ?? hypertension - diastolic 90-100.
	. afebrile - 5 complaints
6/5/71	discharged Granma [redacted]

PATRICK C. [redacted]
DOB: 9/18/63
ISL PVT
056760

PRIMARY CHILDREN'S HOSPITAL
SALT LAKE CITY, UTAH

PHYSICIAN'S ORDER SHEET

DATE AND SIGN EACH ORDER

INK OR BALL POINT PEN

5-29-71

1. Transfer to 4-S
2. V S routinely as directed
3. clear fluids - add ~~Ensure~~ Sustacal

Vleon

5/29

① Demerol 20 mgm IM q 4-6 hrs prn pain.

② Valium 2 mgm PO q 6 hrs prn anxiety.

G. Hale

5/29

① Continue satisfactory

Vleon

Hutton

5/30/71

① DC Demerol & valium

② clear to full liquids

tcc po

prn n.v.

5-30-71 Cancel above order

D/C P. O. Dr. Smoot

Hutton

BARRETT, PATRICK O.
E. DANISE PVT
9/18/63 056760
C33798

5 29 71

COST

DATE

PRIMARY CHILDREN'S HOSPITAL
SALT LAKE CITY, UTAH

PHYSICIAN'S ORDER SHEET

DATE AND SIGN EACH ORDER

USE BALL POINT PEN

~60#

5/28/71 2100

D5 C.75 at 50 cc q 4 hr

Ampicillin gm I IV via pediatrol q 4 hr

ORTHO ORDERS.

1. Ice leg ankle & knee areas -
2. Maintain traction 5#
3. Be careful (R) shoulder - may have dislocated there -
4. DT - Booster 0.5 cc IM.
5. Dress abrasions prn.

5/29

1. Neuro check q 4 hrs

5/30/71 Oz prn

V.O. Dr. Walters

Walters

PATRICK, PATRICK D.
DATE 9/18/63 056760
E. CHASE PVT
DATE 5 28 71 COST

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah
LABORATORY REPORTS

5-31-71 PRIMARY CHILDREN'S HOSPITAL 128704

X Complete Blood Count, CBC | Indices

Wbc	7,800	mm3	MCV		μ^3
Hct	31	Vol %	MCH		µµgm
Hgb	10.1	Gm %	MCHC	33	%
Sedimentation Rate (ESR)		mm/hr	Rbc		mm3

5 21 71 410 25

IP OP ER PVT P.S

BARNETT, PATRICK O.
E. DANISE PVT
033798

CLOCK IN 31 15 05 CLOCK OUT 1 31 00

Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin	Baso	Lymph	Mono
X	100						73	4		21	2

NRBC /100 WBC | Plasma | Turk | Unidentified

Description RBC's NC/NC
Platelet appear adq

Tech [illegible] Date 6-1-71 ORIGINAL HEMATOLOGY 1

PRIMARY CHILDREN'S HOSPITAL 123798

X Complete Blood Count, CBC | Indices

Wbc	20,900	mm3	MCV		μ^3
Hct	39	Vol %	MCH		µµgm
Hgb	13.4	Gm %	MCHC	34	%
Sedimentation Rate (ESR)		mm/hr	Rbc		mm3

PATRICK BARNETTE 7 7

IP OP X PVT P.S

CLOCK IN 28 13 55 CLOCK OUT 28 19 36

Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin	Baso	Lymph	Mono
	100						37			55	8

NRBC /100 WBC | Plasma | Turk | Unidentified

Description NC/NS
platelet adq.
called 7:00 PM
RL

Tech RL Date ORIGINAL 5-28-71 HEMATOLOGY 1

Stat

PRIMARY CHILDREN'S HOSPITAL

328522

Routine	Expedite	X	Stat	Pre Op	Micro Only

Patrick Barnett

IP
OP
ER
PVT
PS

Danise

Color	yellow	Bile	—		
Character	Hazy	MICROSCOPIC			
pH	5	Epithelial Cells	—	lpf	
Specific Gravity	1.021	Casts	—	hpf	

5-28-71 CLOCK IN 19 32 CLOCK OUT [illegible] 28 20 41

Protein	trace	Mucus	trace	lpf	PSP	15 min	30 min
Glucose	—	Wbc	3/5	hpf		60 min	120 min
Reducing Sub	—	Rbc	1/3	hpf	Urobilinogen		
Acetone	—	Bacteria	—		Sulkowitch		
Diacetic Acid	—	Crystals	—		24 Hr. Creatinine		
Occult Blood	~~tr~~ trace				Sulfatase		

Called 8:00PM RL

Remarks:

AS

Tech EL | Date ORIGINAL 5-28-71 URINALYSIS

5- 3 hrs after feeding

PRIMARY CHILDREN'S HOSPITAL

327142

Routine	Expedite		Stat	Pre Op	Micro Only
X					

5 31 71

410-2

BARNETT, PATRICK O.
E. DANISE PVT
[illegible] 056 [illegible]
033798

IP
OP
ER
PVT
PS

Color	yellow	Bile	—		
Character	clear	MICROSCOPIC			
pH	7	Epithelial Cells	—	lpf	
Specific Gravity	1.018	Casts	—	hpf	

CLOCK IN 5[illegible] 19 34 CLOCK OUT 1971 MAY 31 22 01

Protein	—	Mucus	—	lpf	PSP	15 min	30 min
Glucose	—	Wbc	—	hpf		60 min	120 min
Reducing Sub	—	Rbc	—	hpf	Urobilinogen		
Acetone	—	Bacteria	—		Sulkowitch		
Diacetic Acid	—	Crystals	—		24 Hr. Creatinine		
Occult Blood	—				Sulfatase		

Remarks:

Tech [illegible] | Date ORIGINAL 5-31-71 URINALYSIS

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah
LABORATORY REPORTS

5-30-71 PRIMARY CHILDREN'S HOSPITAL 327019

X Routine | Expedite | Stat | Pre Op | Micro Only

IP OP ER PVT PS

BARNETT, PATRICK O.
E. DANISE PVT
033798

Color	Light yellow	Bile	
Character	Clear	MICROSCOPIC	
pH	6.5	Epithelial Cells	hpf
Specific Gravity	1.005	Casts	hpf

CLOCK IN 11 18 CLOCK OUT 30 13 25

Protein	—	Mucus	— lpf	PSP	15 min 30 min
Glucose	—	Wbc	— hpf		60 min 120 min
Reducing Sub	—	Rbc	— hpf	Urobilinogen	
Acetone		Bacteria	—	Sulkowitch	
Diacetic Acid		Crystals		24 Hr Creatinine	
Occult Blood	—			Sulfatase	

Remarks:

Tech KDI Date 5-30 ORIGINAL URINALYSIS

5-30 6:00 PM PRIMARY CHILDREN'S HOSPITAL 128513

IP OP ER PVT P.S

BARNETT, PATRICK O.
E. DANISE PVT
033798

Complete Blood Count, CBC		Indices	
Wbc	m n3	MCV	μ^3
X Hct 35	Vol %	MCH	µµgm
X Hgb 11.4	Gm %	MCHC 38	%
Sedimentation Rate (ESR)	mm/hr	Rbc	mm3

CLOCK IN 11 MAY 30 16 30 CLOCK OUT 11 MAY 30 18 07

Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin	Baso	Lymph	Mono

NRBC / 100 WBC Plasma Turk Unidentified

Description

Tech JM Date ORIGINAL 5-30-71 HEMATOLOGY 1

PRIMARY CHILDREN'S HOSPITAL
Salt Lake City, Utah
LABORATORY REPORTS

12 Am

PRIMARY CHILDREN'S HOSPITAL 126861

Complete Blood Count, CBC		Indices	
Wbc	mm3	MCV	μ^3
Hct 37	Vol %	MCH	µµgm
Hgb 12.8	Gm %	MCHC 35	%
Sedimentation Rate (ESR)	mm/hr	Rbc	mm3

5 29 71

BARNETT, PATRICK O.
L. DANISE PVT
9/18/63 056760

IP OP ER PVT P.S

CLOCK IN 29 00 18 CLOCK OUT 1 [illegible] 29 00 27

Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin	Baso	Lymph	Mono

NRBC /100 WBC | Plasma | Turk | Unidentified

Description

Called 12:25 AM RL

Tech RC Date ORIGINAL 5-28-71 HEMATOLOGY 1

7 Am

PRIMARY CHILDREN'S HOSPITAL 126862

Complete Blood Count, CBC		Indices	
Wbc	mm3	MCV	μ^3
Hct 34	Vol %	MCH	µµgm
Hgb 11.8	Gm %	MCHC	%
Sedimentation Rate (ESR)	mm/hr	Rbc	mm3

5 29 71

BARNETT, PATRICK O.
L. DANISE PVT
9/18/63 056760

IP OP ER PVT P.S

CLOCK IN CLOCK OUT 1971 MAY 29 09

Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin	Baso	Lymph	Mono

NRBC /100 WBC | Plasma | Turk | Unidentified

Description

DV

Tech Rom Date ORIGINAL 5-29 HEMATOLOGY 1

A.M.

PRIMARY CHILDREN'S HOSPITAL 5 29 71 203121

✓	Test	Normal	Result	✓	Test	Normal	Result
	Amylase				Mucoprotein		
	Alkaline Phosphatase	3 1 3 Bodansky			Protein, Total	6.5 7.5 Gms %	
	LDH (Lactic Dehydrogenase)				Albumin	3.5 4.5 Gm %	
	(LDH) Lactic Dehydrogenase				Globulin	2.1 3.5 Gm %	
	Lipase				A/G Ratio		

BARNETT, PATRICK O.
E. DANISE PVT
9/18/63 056760
033798
29 11 18

IP OP ER PVT PS

CLOCK IN CLOCK OUT

✓	Test	Normal	Result	✓	Test	Normal	Result	✓	Test	Normal	Result
	(SGOT) Transaminase	4-30 Units			Thymol Turbidity				Uric Acid	2.6 mg%	
	Bilirubin Direct				Calcium	9.5 11.5 mg%			Glucose	70 100 mg%	
	Indirect			✓	Sodium	136 142 mEq/L	131		Salicylates		
	Total			✓	Potassium	4.1 5.6 mEq/L	4.9		Phosphorus, Ing	4.0 6.5 mg%	
	Ratio			✓	Chloride	98 106 mEq/L	108		Gases, Arterial		
	Cephalin Flocculation	0 1+		✓	CO_2 Content	20 31 mM/L	16.7				
	Cholesterol	150 250 mg%			BUN, Blood Urea Nitrogen	10 17 mg%					
					Creatinine	0.4 1.2 mg%					

Tech BP Date 5-29-71

ORIGINAL BIOCHEMISTRY

5-30 9.00 AM PRIMARY CHILDREN'S HOSPITAL 128512

	Complete Blood Count, CBC		Indices	
	Wbc	mm3	MCV	μ^3
X	Hct 35	Vol %	MCH	µµgm
X	Hgb 11.1	Gm %	MCHC	%
	Sedimentation Rate (ESR)	mm/hr	Rbc	mm3

5 30 71 41032

BARNETT, PATRICK O.
E. DANISE PVT
9/18/63 056760
033798

IP OP ER PVT P.S

CLOCK IN CLOCK OUT 71 MAY 30 11 20

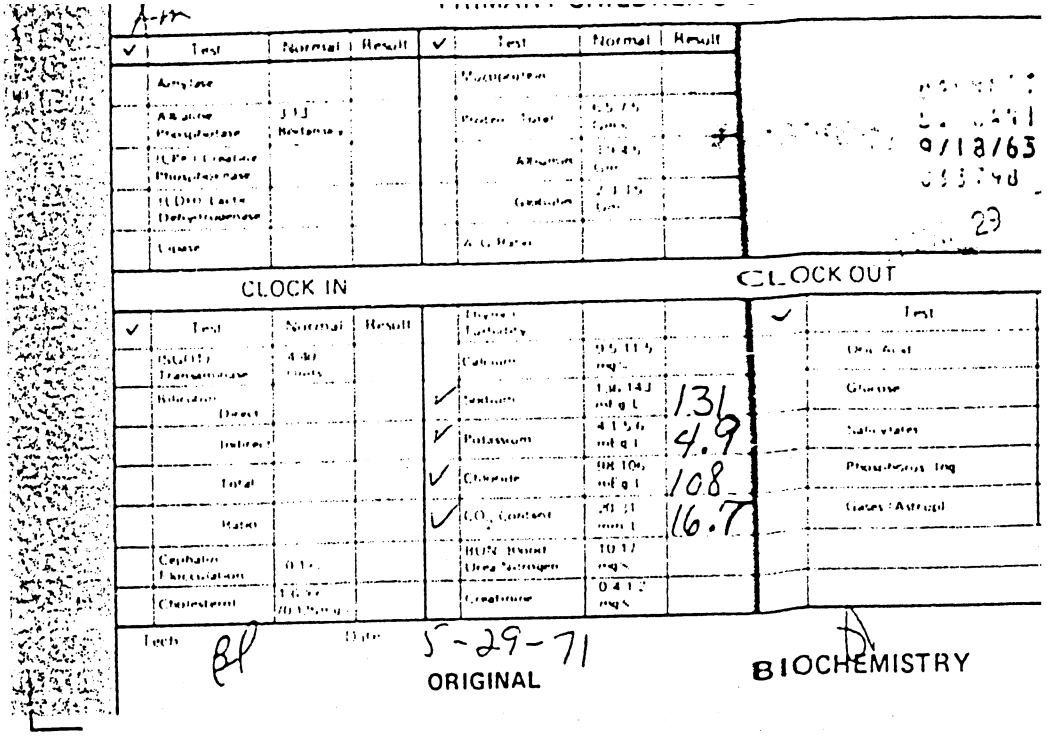
Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin	Baso	Lymph	Mono

NRBC /100 WBC Plasma Turk Unidentified

Description

Tech TOP Date 5-30

ORIGINAL HEMATOLOGY 1



✓	Test	Normal	Result	✓	Test	Normal	Result
	Amylase				Magnesium		
	Alkaline Phosphatase	3 U Bodansky			Protein, Total	6.5-7.5 gms%	
	LDH (Lactic Dehydrogenase)				Albumin	3.5-4.5 gm%	
	Lipase				Globulin	2.1-3.5 gm%	
					A/G Ratio		

CLOCK IN

CLOCK OUT

✓	Test	Normal	Result	✓	Test	Normal	Result
	SGOT (Transaminase)	8-40 Units			Hgb, Turbidity		
	Bilirubin, Direct				Calcium	9.5-11.5 mg%	
	Indirect			✓	Sodium	135-145 mEq/L	131
	Total			✓	Potassium	4.1-5.6 mEq/L	4.9
	Ratio			✓	Chloride	98-106 mEq/L	108
	Cephalin Flocculation	0-1+		✓	CO_2 Content	20-27 mm/L	16.7
	Cholesterol	150-250 mg%			BUN (Blood Urea Nitrogen)	10-17 mg%	
					Creatinine	0.4-1.2 mg%	

✓	Test
	Uric Acid
	Glucose
	Salicylates
	Phosphorous, Inog
	Gases: Astrup

Tech BL Date 5-29-71

ORIGINAL

BIOCHEMISTRY

PRIMARY CHILDREN'S HOSPITAL

5-30 9.00 AM

5 30 71

BARNETT, PA
L. DANISE P
9/18/63 054
033798

Complete Blood Count, CBC			Indices	
Wbc		mm3	MCV	μ^3
X Hct	33	Vol %	MCH	μμgm
X Hgb	11.1	Gm %	MCHC	%
Sedimentation Rate (ESR)		mm/hr	Rbc	mm3

CLOCK IN

CLOCK OUT

Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin

NRBC / 100 WBC | Plasma | Turk | Unidentified

Description

Tech KOL Date 5-30

ORIGINAL

HEMATOLO

BLOOD BANK REQUEST

PRIMARY CHILDREN'S HOSPITAL

Routine ☐ Expedite ☐ Stat ☐

Time and date to be given: 6-1-71

Diagnosis: auto injuries

Indication for Transfusion:

Ordered by: Dr Affleck

Signature of Dr. ordering blood: JUN 1 18 57

Signature of Person Filling Out Request: A. Affleck

Hospital Doctor Name Room Date No.

5 31 71

410621

BARNETT, PATRICK O.
E. DANISE PVT
7715765 056760
033798
JUN 2 10 35

This blood is ready and will be released in 3 days unless Blood Bank is notified.

Units of:
Whole Blood: 1u Packed red cells: Plasma: Misc.:

Patient:
Blood group O Rh type Pos hr Pos Screening Neg with Saline

Blood Bank Number	Blood Group	Rh Type	Saline Major	Saline Minor	High Protein Major	High Protein Minor	Coombs Major	Coombs Minor
1. 71-0148	O	Pos	ok	ok	ok	ok	ok	ok
2.								
3.								
4.								
5.								
6.								

Date: 6-2-71 Technologist's Signature R. Hutchinson

88-2—4-68 Re:

6-2- AM PRIMARY CHILDREN'S HOSPITAL 128517

Complete Blood Count, CBC		Indices	
Wbc	mm3	MCV	μ^3
✓ Hct	34, Vol %	MCH	μμgm
Hgb	Gm %	MCHC	%
Sedimentation Rate (ESR)	mm/hr	Rbc	mm3

BARNETT, PATRICK O
E. DANISE PVT
7715765 056760
033798
JUN 2 09 37

IP OP ER PVT P.S

CLOCK IN 12 07 CLOCK OUT JUN 2 09 37

Differ Count	Count	Blast	Promyelo	Myelo	Meta	Band	Neut	Eosin	Baso	Lymph	Mono

NRBC / 100 WBC Plasma Turk Unidentified

Description

Tech 19. Date ORIGINAL 6-2-71 HEMATOLOGY 1

Plaintiff Letter re: Hearing
to Judge Henriod and Salt Lake City Corporation

DEAR JUDGE COURTROOM AND SALT LAKE CITY ATTOURNEY

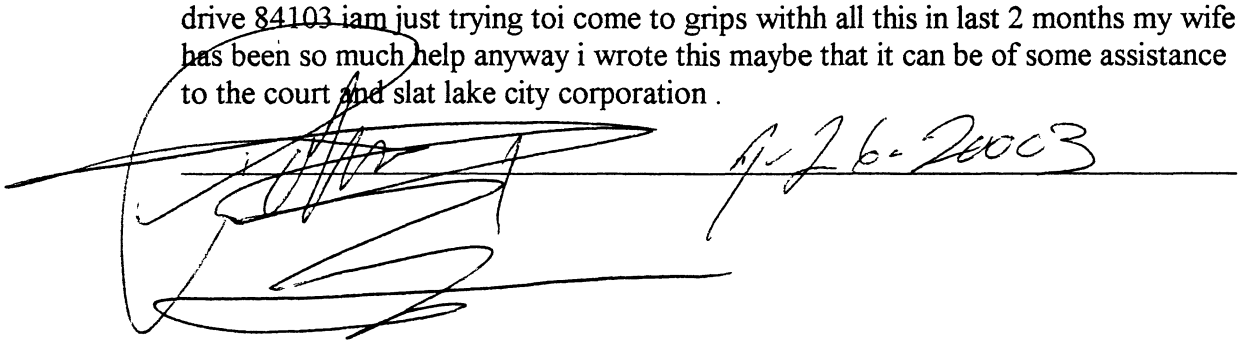
This is very hard on me but i must write this letter so maybe everyone involved can try and understand what i go threw on a daily basis you see its realy hard when people say patrick remember the time such and such happened and i do not remember but i say yes so i can fit in well i dont like that, its painfull that i cant rember things on a daily basis it hurts having family and friends that ask over and over again remeber this or that i dont remember and i clue them in on what i have written down and learned in the last few months and i let them know but yet people still ask at times hey patrick rember this and it makes me sad/angry/frusterated/etc,

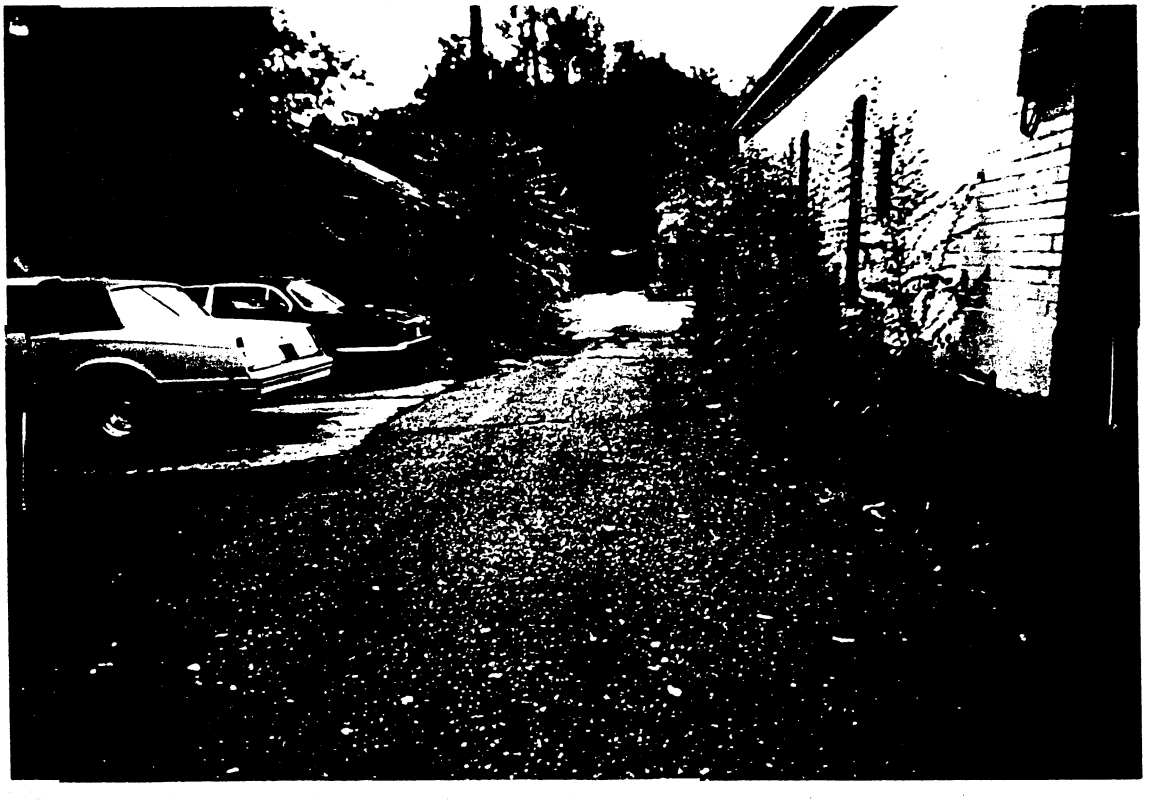
on a daily basis i sometimes have visual problems or noises are very very loud to me have to constantly think over and over when iam doing something or i tend to forget i want what most have a good job a career but seems iam only fooling myself as i have tried and i cant becuase i forget things i get scared and in fear out of no where i have panic attacks i get dizzy at times people cant understand what iam talking about or so they say i change a subject on a dime or jumble things up in my words its so frustering ,

after the court hearing my brother and wife said pat why did you not tell them everything ,well again some days i cant even think straight let alone put words in context so others can understand the judge asked me so why you filing this case now , well my answer to that is because i have had help to undertsand why i have these problems and such my wife couldnt handle my night mares i went to therapy then therapy had me go to the place i was ran over at then i went to the govener then the govener sent me to the major then the major sent me to the court in a mannor its all a fog to me you see i dont remeber when i was 8 years old or 14 or 20 or 25 or 28 etc,etc, i know i get head aches my hip hurts my knee hurts my shoulder hurts and swells i get vision problems and noise gets loud when its realy not and when people talk to me its jumbled at times and i get frusterated and angry so my wife actualy put me on this course of action and in all light i think she has helped me a great deal a injustice done to me my life was torn apart by this when i was a child ,it angers me that know one helped me before why why why ? i ask that makes me even more angry and the place i was hit you see salt lake city has a responsability to its tax payers in my oppinion for there safety to some extent and that alley throughway i was hit at had no safety it came off a major street with 2 inlets to a residential neighberhood with blocked views and after my accident iam told by residents there in the past 2 weeks they said patrick after you was hit we pettioned salt lake city utah to close the entire all through way because of traffiic and no signs and its dangers for years finaly they closed the south end of the alley and still to date the rest is a danger i dont understand why this is ,

further more i appoligize to the judge henriod that i did not say in the hearing what iam now like i said at times i cant even focus or undertsand or talk right if the judge wants me to i will meet in a court room again and i will try my best to say what iam now my memory fails me and i have worse days then others my appoligies to the salt lake city attourney and the judge i will try better i have

seeked help from the utah brain injury instatute and iam on medicine for my p.t.s.d and i have note pads now and hope i can get a recoreder to help me in my daily issues so i can have something to remeber and go on but in all manor i have paid dearly in my oppinion says age 7-8 in the last 2 months i have lerned more about myslef then i have ever known well of what i think i have known or remebr its hard to realy know and what the brain instatute told me on the phone thats what traumatic brain injury does mesess up your thoughts memory all kinds of junk i asked them if they can fix it they said sorry we can not fix what happened when you got those head fractures , i looked on my medical papers and called the emergacy docter one of them taht worked on me he said its a miracle you are alive i said thanks for your help in saving me he said it was god and that he can not explain medicaly why iam alive to day i cant belive he rembered me his name is dr.owen smoot here is his phone # 532-2920 his address is 849 north juniperpoint drive 84103 iam just trying toi come to grips withh all this in last 2 months my wife has been so much help anyway i wrote this maybe that it can be of some assistance to the court and slat lake city corporation .





PLAT SHOWS :

1. ALLEYWAY WHERE ACCIDENT HAPPENED.

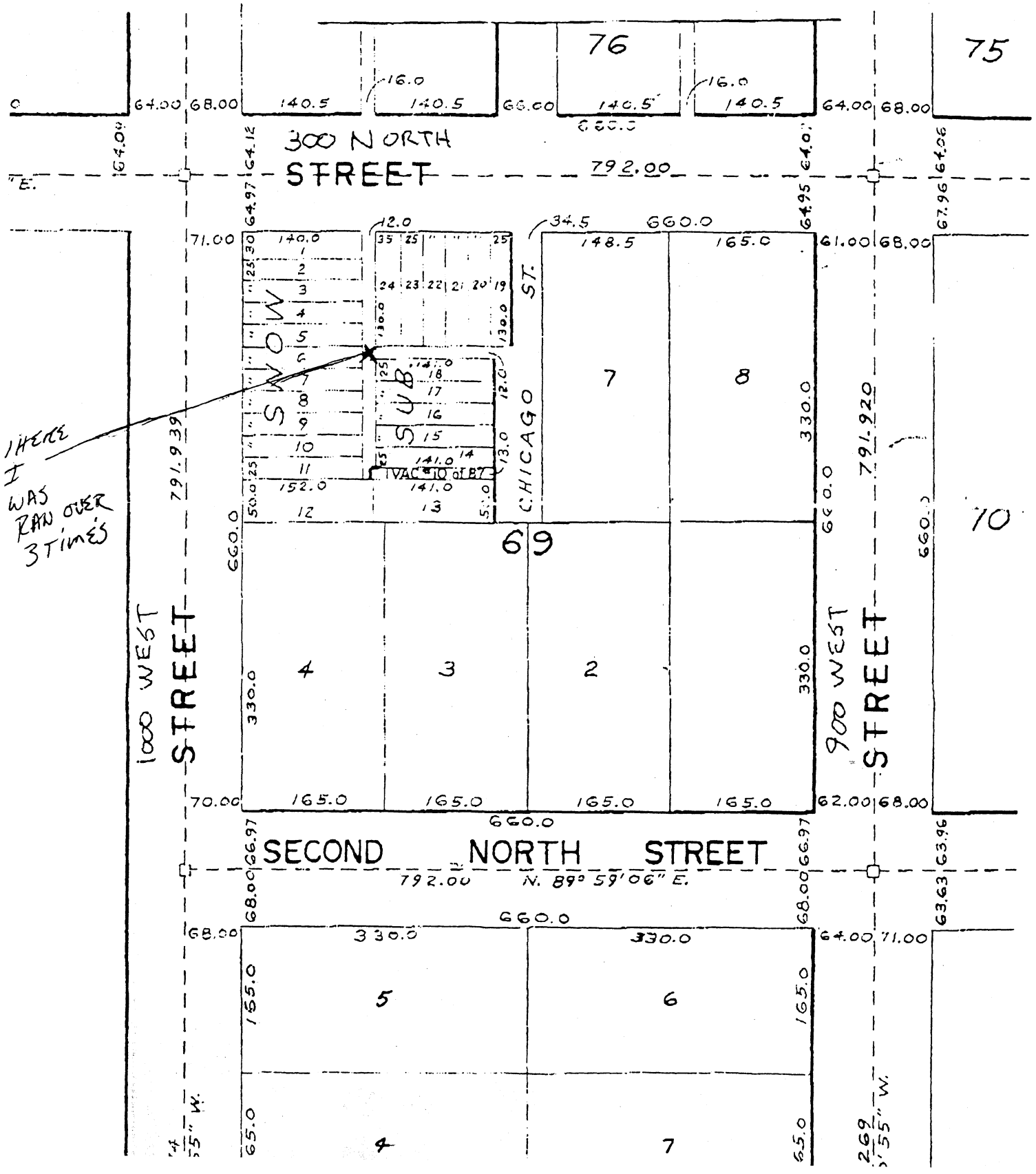
2. GARAGE ON SOUTHEAST CORNER WHICH WAS PUT UP BY RESIDENT AND APPROVED BY THE CITY WITH PERMIT AND PARCEL # PRIOR TO ACCIDENT.

3. GARAGE WAS ALSO THE SOURCE OF THE BLOCKED VIEW DESCRIBED IN POLICE REPORT.

4. AN ALLEYWAY GOING ONTO CHICAGO STREET THAT WAS BLOCKED OFF AFTER THE ACCIDENT DUE TO PETITION SIGNED BY RESIDENTS ASKING THAT THE WHOLE ALLEY BE BLOCKED.

Post-it® Fax Note 7671	Date 9/8/2000	# of pages ▶ 1 of 1
To Patrick Whisphuby	From Bob Sorsic	
Co./Dept.	Co. Salt Lake City	
Phone #	Phone # 535 6457	
Fax # 963-0439	Fax # 535 6093	

PLAT 10)



POLICE REPORT SHOWS :

1. That the officer on duty stated that both driver and victim upon entering the alley at the same time had a blocked view.

2. That Mrs. Brown was the driver of the vehicle.

INVESTIGATING OFFICER'S REPORT OF TRAFFIC ACCIDENT — STATE OF UTAH

TIME

DATE OF ACCIDENT: MAY 28 '71 — Day of Week: FRIDAY — Hour: 5:30 A.M. ☐ P.M. ☒

DO NOT WRITE IN THIS SPACE

MAY 29 7 06 AM

RECORDS CERTIF

LOCATION

PLACE WHERE ACCIDENT OCCURRED: County: SALT LAKE — City or town: SALT LAKE

If accident was outside city limits, indicate distance from city limits of nearest town ..... miles ☐ North ☐ S ☐ E ☐ W ☐ of 71-24348 City or Town

ROAD ON WHICH ACCIDENT OCCURRED: ALLEY — Give name of street or highway number

AT ITS INTERSECTION WITH: REAR OF 971 WEST 2ND NORTH — Name of intersecting street or highway number

IF NOT AT INTERSECTION: 169 feet ☐ North ☒ S ☐ E ☐ W ☐ of 2ND NORTH — Nearest intersecting street, house no., landmark.

..... lengths of a mile ☐ North ☐ S ☐ E ☐ W ☐ of [illegible] — DO NOT USE TO CONSTRUCT IF ROAD HAS MILEPOSTS

ACCIDENT INVOLVED:	Two motor vehicles ☐	More than two motor vehicles ☐	Pedestrian ☐	Bicycle ☒	Animal ☐	Fixed object ☐	Ran off road ☐	Overturned in road ☐	Other ☐

Attach supplement (Form SR 9-S) if accident involved any of the above.

VEHICLE NO. 1

VEHICLE:	Year: 1968	Make: MERC	Model: COUGAR	Body Style: 2DR.	Type: 5 PAS HDT.	Identification No.: 8R93J507642
Odometer Reading	LICENSE PLATE:	Year: 1971	State: UTAH	Number: F4 8858	STICKER NUMBER: NONE	
Parts damaged: IMPACT — FRONT BUMPER					Cost of Repair: $ 100.00	
Removed to: RETAINED		By: OWNER			On Authority of	
OWNER: Full name: DARRELL GRAHAM				Street, City, State: 1025 LINCOLN STREET S.L.C. UTAH		
DRIVER: Full name: LEAH LOUISE HILL BROWN				Street, City, State: 253 CHICAGO STREET S.L.C. UTAH		

Driver's License: State UTAH Number A15193 ☒ Regular ☐ Other Type ... Specify Type and/or Restrictions OP/NONE — Date of Birth: Month 4 Day 19 Year 19

Total number vehicles involved: 1

OCCUPANTS:	Name	Address	Age	Sex	Seat Belts	Injury	Ejection	Through what area ejected?
Front Center			52	F	U	0	NO	
Front Right	DARRELL GRAHAM	1025 LINCOLN STREET	—	M	U	0	NO	
Rear Left								
Rear Center 1								
Rear Center 2								
Rear Right								

VEHICLE NO. 2

VEHICLE:	Year:	Make:	Model:	Body Style:	Type:	Identification No.:
Odometer Reading	LICENSE PLATE:	Year:	State:	Number:	STICKER NUMBER:	
Parts damaged					Cost of Repair: $	
Removed to		By			On Authority of	
OWNER: Full name				Street, City, State		
DRIVER: Full name				Street, City, State		

Driver's License: State Number ☐ Regular ☐ Other Type ... Specify Type and/or Restrictions — Date of Birth: Month Day Year

OCCUPANTS:	Name	Address	Age	Sex	Seat Belts	Injury	Ejection	Through what area ejected?
Front Center								
Front Right								
Rear Left								
Rear Center 1								
Rear Center 2								
Rear Right								

LAP AND SHOULDER BELT CODE

Enter proper code letter for each driver and occupant whether injured or not.

LAP BELT ONLY
- N - None installed
- F - Fastened
- U - Unfastened
- D - Not reported

LAP & SHOULDER BELT ONLY
- E - Not used
- G - Lap belt only used
- H - Both belts used
- X - Not reported

INJURY CODE

- K - Dead before report made.
- A - Visible signs of injury, or bleeding wound or distorted member; or had to be carried from scene
- B - Other visible injury, as bruises, abrasions, swelling, limping, etc.
- C - No visible injury but complaint of pain or momentary unconsciousness.
- O - No indication of injury.

SR-9 (P-28)

TYPE OF LOCALITY (Check one)
1 ☐ Manufacturing or industrial
2 ☐ Shopping or business
3 ☒ Residential
4 ☐ School
5 ☐ Farms and fields
6 ☐ Open country

ROAD SURFACE (Check one)
1 ☒ Dry
2 ☐ Wet
3 ☐ Muddy slippery
4 ☐ Snowy slippery

LIGHT CONDITION (Check one)
1 ☒ Daylight
2 ☐ Dawn or dusk
3 ☐ Dark—No street lights
4 ☐ Dark—Street lights

WEATHER (Check one)
1 ☒ Clear or cloudy
2 ☐ Raining
3 ☐ Snowing
4 ☐ Fog
5 ☐ Dust

TRAFFIC CONTROL (Check one or more)
1 ☐ Officer or watchman
2 ☐ Flasher
3 ☐ Traffic signal
4 ☐ Traffic signal—flashing
5 ☐ Stop sign
6 ☐ Yield sign
7 ☐ R.R. gates or signal
8 ☐ _____
9 ☒ Specify other No control present

ROAD CHARACTER (Check one)
1 ☒ Straight—Level
2 ☐ Straight—Grade
3 ☐ Straight—Hillcrest
4 ☐ Curve—Level
5 ☐ Curve—Grade
6 ☐ Curve—Hillcrest

ALCOHOL TESTS
Type:
Results: None Given

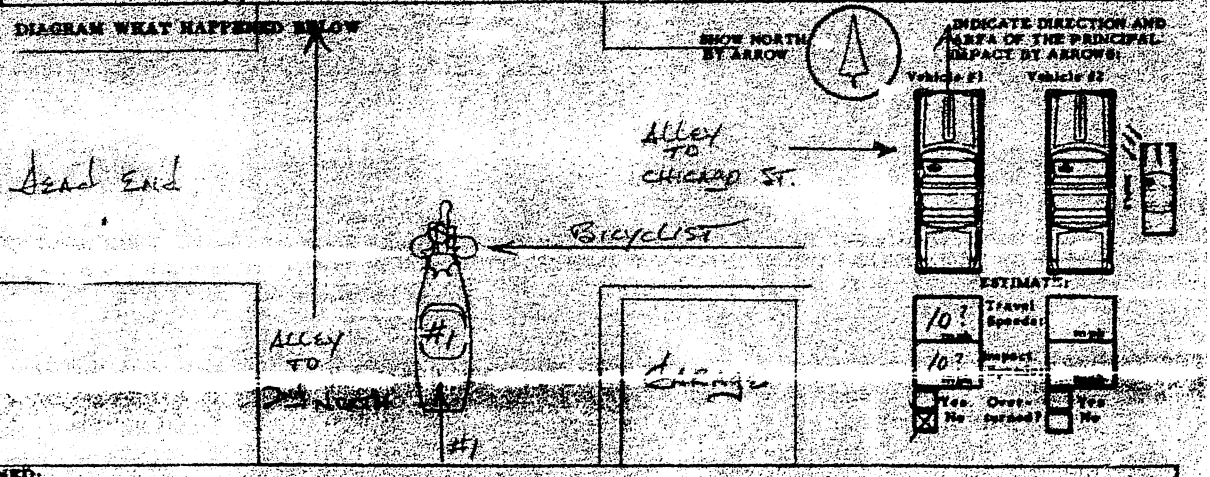
WHAT DRIVERS WERE DOING JUST BEFORE ACCIDENT
Driver No. 1 was headed N ☐ E ☐ S ☐ W ☐ on Alley To 2nd North Street or highway
Driver No. 2 was headed N ☐ E ☐ S ☐ W ☐ on _____ Street or highway

Driver	1	2	Driver	1	2	Driver	1	2	Driver	1	2
	☒	☐		☐	☐		☐	☐		☐	☐
Go straight ahead			Make left turn			Start in traffic lane			Remain stopped in traffic lane		
Overtake	☐	☐	Make U turn	☐	☐	Start from parked position	☐	☐	Remain parked	☐	☐
Make right turn	☐	☐	Slow or stop	☐	☐	Back	☐	☐			

CONTRIBUTING CIRCUMSTANCES (Check one or more for each driver) 71-24348

Driver	1	2	Other Improper Driving	Driver	1	2	Vehicle Defects	Driver	1	2
0 Did not contribute	☐	☐								
Pending										
1 Speed too fast	☐	☐	10 Under the influence of drugs		☐	☐	20 Brakes defective		☐	☐
2 Failed to yield right of way	☐	☐	11 Driving defective—uncorrected		☐	☐	20 Headlights insufficient or out		☐	☐
3 Drove left of center	☐	☐	12 Asleep		☐	☐	21 Headlights glaring		☐	☐
4 Improper overtaking	☐	☐	13 Fatigued		☐	☐	22 Other lights or reflectors defective		☐	☐
5 Passed stop sign	☐	☐	14 Ill		☐	☐	23 Steering mechanism defective		☐	☐
6 Disregarded traffic signal	☐	☐	15 Improper parking		☐	☐	24 Tires defective		☐	☐
7 Followed too closely	☐	☐	16 Improper lookout		☐	☐	25 Windshield not clear		☐	☐
8 Made improper turn	☐	☐	17 Failed to signal		☐	☐	26 Other defective condition of vehicle		☐	☐
9 Had been drinking	☐	☐	18 Other improper driving		☐	☐				

DIAGRAM WHAT HAPPENED BELOW



DESCRIBE WHAT HAPPENED: (Refer to vehicles by number)
Bicyclist Westbound in Alley From Chicago Street, Vehicle #1 Northbound in Alley Leading To 2nd North, Garage on Southeast Corner of the Intersection Alleys Blocked View For Both the Bicyclist & the Motorist. Both Bicyclist & Motorist entered Intersection At Approximately the Same Time & A Collision Occurred.

☐ Continued on supplement (Form SR 3-S)

WITNESSES

Name	Address	AGE	SEX
Fred W. Schwarz	971 West 2nd North	69	M

FIRST AID GIVEN BY: Intermountain Ambulance Injured Taken to: Primary Children's By Intermountain

POLICE ACTIVITY
Time notified of accident May 28, 1971 (Date) 5:34 (Hour) A.M. ☐ P.M. ☒ What was the source of accident information? Driver #1 - Scene - Witness (Officer at scene, No. 1 driver contacted station, etc.)
Investigation of accident was completed at 7:14 (Hour) A.M. ☐ P.M. ☒ of ☒ the same day ☐ the _____ day following
Arrests
Name Pending Charge
Name Charge
Other action taken: Photos

SIGN HERE Ptm V.B. Devenish A-02 1A SLCPD May 28, 1971
Officer's rank and name Badge No. Department Date of report

State law requires that report be forwarded to Dept. of Public Safety within 24 HOURS following completion of investigation.
Mail ORIGINAL of report to: Financial Responsibility Division, 305 State Office Bldg., Salt Lake City, Utah 84114.

6/18/2003

SOUTH VALLEY ADULT PGM
7434 S STATE ST
SALT LAKE CITY UT 84047

PATRICK O BARNETT
3253 WESTGENE CIR
SALT LAKE CITY UT 84119

801-566-1423

849-1250 D.O.B. 9/19/1963

Rx#: [illegible] 3101 PAXIL CR 25MG #30 1 QD SC PO 0 refills

BILL TO: MEDICAID
09024171910

MARK DUDLEY APRN

ST LIC 1361364405

VALLEY MENTAL HEALTH

Not Legal If Photo Copied

PATIENT INSURANCE / TAX
FOR THE DATES 12/10/2000 THRU 06/24/2003

ALBERTSONS PHARMACY #381
3555 WEST 3500 SOUTH
WEST VALLEY CITY UT 84119

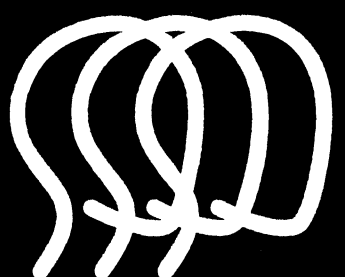
PH - (801) 963-6874
DEA - BA4096726

PATIENT: PATRICK BARNETT

TYPE: B
SEX : M
BIRTH DATE: 09/19/1963

RX #	REF	DISPENSED	QTY	DRUG / NDC	DOCTOR / SPEC		PATIENT PAID	T.P. PLAN	PRIMARY INSURANC PAID\BII
215237		06/18/2003	30	PAXIL CR 25MG TABLET 000029-3207-13	MARK	DUDLEY	3.00	MEDUT	75
204439	1	03/12/2003	42	CIPRO 500MG TABLET 000026-8513-51	ODELL	RIGBY	3.00	MEDUT	201
202350		02/24/2003	60	IBUPROFEN 600MG TABLET 049884-0468-05	NANCY	DAIN	3.00	MEDUT	4
201771		02/19/2003	21	CELEBREX 200MG CAPSULE 000025-1525-31	ODELL	RIGBY	3.00	MEDUT	52
201770		02/19/2003	20	LEVAQUIN 500MG TABLET 000045-1525-50	ODELL	RIGBY	3.00	MEDUT	172
184318		09/20/2002	14	TRAMADOL HCL 50MG TABLET 000093-0058-01	RANDY	BLACK	1.00	MEDUT	13
178700		07/31/2002	20	NAPROXEN SODIUM 550MG TAB 000093-0537-01	KIM	HEATON	1.00	MEDUT	17
178699		07/31/2002	200	HISTINEX HC SYRUP 058177-0877-07	KIM	HEATON	1.00	MEDUT	13
171833		05/30/2002	20	ULTRAM 50MG TABLET 000045-0659-60	GEOFFREY	ORME	1.00	MEDUT	19
161451		03/05/2002	30	PROCTOSOL-HC 2.5% CREAM 063304-0407-01	ROBERT	NIELSEN	1.00	MEDUT	21
161451	1	03/15/2002	30	PROCTOSOL-HC 2.5% CREAM 063304-0407-01	ROBERT	NIELSEN	1.00	MEDUT	21
161451	2	05/08/2002	30	PROCTOSOL-HC 2.5% CREAM 063304-0407-01	ROBERT	NIELSEN	1.00	MEDUT	21
							---		---
PATIENT TOTALS:		PRESCRIPTIONS -	12				22.00		635
TOTALS:		PRESCRIPTIONS -	12				22.00		635

What Everyone Should Know



BRAIN INJURY ASSOCIATION OF UTAH, INC.

1800 South West Temple, Suite 203
Salt Lake City, Utah 84115
(801) 484-2240 • (800) 281-8442
www.biau.org – biau@sisna.com

"AT LAST — SOMEONE UNDERSTANDS"

(ICU) services not necessarily related to the head trauma.

9. What is medical stabilization?

Many brain injury patients require time in the hospital for medical treatment such as recovery from surgery, healing of wounds, and setting of fractures. This is known as medical stabilization. Patients may be transferred from the emergency room or ICU, to a medical floor for observation, medical treatment and the beginning of rehabilitation services such as physical therapy.

10. What happens after medical stabilization?

After the patient has gone through medical stabilization, which can take from several days to several months, there are a variety of directions which may be taken.

A. The Patient may be transferred to a physical rehabilitation unit within a general hospital, or a specialized rehabilitation treatment center providing skilled nursing care. Physical, occupational, speech/cognitive and neuropsychological services can be provided on an intensive basis.

B. Some patients will not require skilled nursing care and may be transferred to a community program for brain injury patients. These programs offer both inpatient and outpatient services.

C. Some patients will go home with their families and return to the hospital or a specialized outpatient program for their therapies and treatment.

D. Some patients who require extended skilled nursing care will be transferred to a long term care facility.

E. Some patients will return home to receive therapy and around the clock nursing care

11. What is rehabilitation?

Rehabilitation is the process which helps an individual reach optimum function by providing a variety of services. Rehabilitation often uses a team concept which includes services of the physicians as well as physical, occupational and speech therapists, neuropsychologists, social workers, therapeutic recreational specialists, and nurses. In addition, other professionals in education and vocational training help provide treatment services. However, the most important members of the treatment team are the patient and the patient's family.

12. Which is the best choice?

The appropriate choice for continued treatment is a major decision to be made by the patient and family. It is important to talk to your treatment team and fully understand the patient's needs. You must seek out as much information as possible to educate yourself about available resources.

13. What do families go through?

Shock, anger, hurt, denial, and depression are some of the reactions families experience. A loved one's brain injury can change the family's life as well. A grown and independent child may require more attention from you. An injured parent may need the assistance of adult children,. As the patient goes through the stages of recovery, so does the family. Support and guidance may help you deal with changes which are ahead. The key is to take one day at a time.

14. Signs of stress.

The stress placed on the family of the brain injured is tremendous. Each individual and family will handle and cope with stress differently. The signs of stress may include the following: inability to sleep, poor appetite, lack of interest in personal care or appearance, a strong sense of guilt, reduced self worth, loneliness, excessive use of drugs or alcohol, forgetfulness, or an inability to understand things that are said. When stress builds seek support from friends, clergy, and the medical staff caring for your brain injured individual.

15. What can the family expect?

Every brain injury case is different. You cannot compare brain injuries like you can a broken arm or leg. The effects of each brain injury are very individualized. No one person has all the answers. You must start to read and gather information on brain injury, its effects and possible treatment avenues open to you. Educating yourself is important in setting realistic expectations.

16. Helpful suggestions for families.

- Establish a balance between pushing the brain injured person beyond his or her ability to function and not giving enough encouragement.
- Establish and maintain a daily routine.

t Message from the Brain Injury lssociation of Utah

People who have suddenly become involved with aumatic brain injury often wonder where they can find ɔmeone who can tell them what to expect. Some fear ıey may not be getting candid answers and others esitate to ask questions due to their concern over the nswers they receive. The simple truth is that no one an accurately predict all eventual outcomes. This ɜaves family members, as well as those who have been ıjured, perched somewhere between high hopes and eep despair.

The Brain Injury Association of Utah is always vailable to assist people who have these concerns. he BIAU has members throughout the state, many of /hom have experienced every conceivable kind of ustration and uncertainty. Call the BIAU office at (801) 84-2240 or 1-800-281-8442. We'll help you make onnections with people who can make the difference.

l. What is traumatic brain injury?

There are over 750,000 brain injuries each year /hich require hospitalization. Traumatic brian injury is n insult to the brain, not of a degenerative or ongenital nature but caused by an external physical ɔrce or by internal damage such as anoxia (lack of xygen) or tumor. It may produce a diminished or ltered state of consciousness, which results in npairment of cognitive abilities and physical ınctioning. These impairments may be either ɜmporary or permanent and cause partial or total ınctional disability or psychosocial maladjustment. ifty percent of brain injuries occur as a result of a ıotor vehicle accident.

2. What does the brain do?

The brain is the center of our body's control system.)ne part of the brain controls our breathing, heart beat nd circulation. Other parts of the brain control our ision, physical movement, memory, hearing, and motions, to name a few. The brain is our most vital rgan and is involved in every aspect of our body's ınctioning.

3. What is a concussion?

A concussion results from a blow to the head which auses the brain to strike the skull. A concussion does ot cause any structural damage to the brain, but can ause temporary loss of functioning. Headaches, memory loss, and sleep disturbance may be some of the problems suffered after such an injury.

4. What is a contusion?

A contusion is a more serious blow to the brain, which results in bruising of the brain and more noticeable loss of functions. More comprehensive care is required for a contusion. Follow-up treatment and evaluation are required on a regular basis.

5. What is a skull fracture?

A skull fracture results in damage to the skin and bone of the skull as well as to the brain itself. The form of medical treatment varies with the location and severity of the fracture. Close observation and follow-up treatment are always required. Many skull fractures result in mild to severe problems associated with daily functioning such as walking, memory, vision, and behavior.

6. What is a hematoma?

The collection of blood in one or several locations of the brain creates a hematoma. A hematoma may be between the skull and the covering of the brain (epidural) or may occur between the membrane covering the brain and the brain itself (subdural). Hematomas may require surgery (a craniotomy) to be performed.

7. What is a coma?

Coma is defined as a prolonged state of unconsciousness. A person in a coma does not respond to external stimuli. There is no speech, the eyes are closed and the person cannot obey commands.

Coma can last from hours to days, depending on the severity of the brain damage. It is possible for a person to remain in a comatose state for months or even years. A person may eventually open their eyes, but if they remain unresponsive, they could be in what is termed a "vegetative state."

8. What happens in the emergency room and Intensive Care Unit?

Most accident victims enter the hospital through the emergency room. The injury is diagnosed and appropriate action is taken. Some patients must go to the Intensive Care Unit (ICU) of the hospital for close, 24 hour monitoring of their condition. Other injuries sustained at the time of the brain injury may require

trauma.

9. What is medical stabilization?

Many brain injury patients require time in the hospital for medical treatment such as recovery from surgery, healing of wounds, and setting of fractures. This is known as medical stabilization. Patients may be transferred from the emergency room or ICU, to a medical floor for observation, medical treatment and the beginning of rehabilitation services such as physical therapy.

10. What happens after medical stabilization?

After the patient has gone through medical stabilization, which can take from several days to several months, there are a variety of directions which may be taken.

A. The Patient may be transferred to a physical rehabilitation unit within a general hospital, or a specialized rehabilitation treatment center providing skilled nursing care. Physical, occupational, speech/cognitive and neuropsychological services can be provided on an intensive basis.

B. Some patients will not require skilled nursing care and may be transferred to a community program for brain injury patients. These programs offer both inpatient and outpatient services.

C. Some patients will go home with their families and return to the hospital or a specialized outpatient program for their therapies and treatment.

D. Some patients who require extended skilled nursing care will be transferred to a long term care facility.

E. Some patients will return home to receive therapy and around the clock nursing care.

11. What is rehabilitation?

Rehabilitation is the process which helps an individual reach optimum function by providing a variety of services. Rehabilitation often uses a team concept which includes services of the physicians as well as physical, occupational and speech therapists, neuropsychologists, social workers, therapeutic recreational specialists, and nurses. In addition, other professionals in education and vocational training help provide treatment services. However, the most

Use familiar photographs of family members, friends, pets or possessions .

Speak of familiar names, places, interests, or activities.

Be yourself with the brain injured.

Do not overwhelm or overload the person with information.

Provide the individual with ample time to respond.

Do not present the person with a task that is too complex.

Try to reduce confusion in his/her surroundings.

Talk openly about his/her gains and abilities.

Communicate with the doctors, nurses, therapists, and the brain injured individual.

Where can the family go for information l support?

To obtain further information and to locate the irest support group, see the BIAU brochure or call 1) 484-2240 or 1-800-281-8442.

at is the BIAU?

The Brain Injury Association of Utah is a nonprofit anization made up of brain injured survivors, family mbers, friends and professionals dedicated to viding information, advocacy and support. The BIAU a chartered association of the Brain Injury ociation, Inc.

Our goals

he Brain Injury Association of Utah fully supports the major goals established by the Brain Injury ociation, Inc. These goals range from prevention to rehabilitation.

problems of brain injury.

2. Provide a central clearinghouse for information and resources for the brain injured and their families.
3. Develop a support group network for the brain injured and their families.
4. Established specialized brain injury rehabilitation programs. Encourage existing programs and develop new programs where none exist.

20. Why is support from others important?

You cannot go through this trauma alone! We all need support from those who understand the pain and loss we are suffering. Support groups for both the patient and family are available to you. Take advantage of this now!

GLOSSARY

This is only a partial list of the hundreds of terms and specialties associated with brain injuries.

CT Scan: Computerized Tomography (like an X-Ray) is a test which takes a close look at the functioning of the brain by projecting an accurate picture. This test helps locate physical damage to the brain.

EEG: The electroencephalogram measures "electrical" currents from nerve cells of the brain. This test helps diagnose specific neurological conditions, especially the presence of a seizure disorder.

EKG: The electrocardiogram measures variations in the heart and heart muscle by connecting electrodes to the chest. Patients in the emergency room and intensive care units often are monitored with a EKG to assure normal heart functioning.

ICP Monitor: Intracranial Pressure Monitor indicates pressure within the brain. It consists of a small tube attached to the patient at the skull and then to a monitoring device. The ICP monitor helps assure close observation of activity within the brain which may result in swelling of the brain.

Medical Social Worker: A professional who helps arrange services and programs for the patient and family by communication between other professionals, insurance payer, patient and family. The Medical Social Worker is instrumental in discharge planning.

Neuropsychologist: A specialist involved in evaluation and treatment in the functional behavioral aspects of rehabilitation. The Neuropsychologist evaluates actual brain functioning in relation to real life activities,

Neurosurgeon/Neurologist: A physician who specializes in the treatment of patients with a variety of brain functioning difficulties. The surgeon may perform brain or spinal cord surgery when indicated.

Occupational Therapist: A professional who uses purposeful activity in the treatment of physically impaired individuals and helps them achieve maximum optimal functioning. The following areas are evaluated and addressed in the treatment of the brain-injured person as appropriate: self care skills; cognitive/visual perceptual retraining; sensory stimulation; splint fabrication; upper extremity gross and fine motor activities; practical community skills such as prevocational training, money management and home visits to adapt physical environments to specific needs.

Physiatrist: A physician specializing in physical medicine and rehabilitation is involved in the evaluation of physical functioning of the body following injury and during the patient's rehabilitation.

Physical Therapist: A professional who evaluates and treats the brain inured patient for neuromuscular deficits to maximize the patient's return to functional activities. Interventions include posturing, adaptive equipment, therapeutic exercise, motor planning activities, transfer and gait training.

Speech-Language Pathologist: A Professional who evaluates and treats disorders of comprehension, reading, memory, orientation, oral-motor functioning, writing and cognition which may be present following a closed brain injury.

Please call us at:
(801) 484-2240 or
(800) 281-8442
www.biau.org
biau@sisna.com

BRAIN INJURY ASSOCIATION OF UTAH, INC.

For Information on Local Support Groups see BIAU Brochure

BRAIN INJURY ASSOCIATION OF UTAH, INC.

MAKING HEADWAY

1800 South West Temple • Suite 203 • Salt Lake City, Utah 84115 • HELP LINE (801) 484-2240 or (800) 281-8442 • Fax (801) 484-5932 • email biau@sisna.com

ISSUE 1 2002

Negotiating The Security Maze

By G. Barrie Nielson

Eddie Chavez (not his real name) was disappointed and overwhelmed. He had just received another unfavorable decision on his Social Security Disability Insurance claim. Eddie has worked and paid into Social Security for most of his life. Unfortunately he has been the victim of a beating in a restaurant restroom in Singapore while serving in the military. He had been able to work in menial jobs for many years but his health has deteriorated. He was now having memory and concentration problems and was having a hard time communicating with people. He had worked at his job as long as he could but finally his employer had to let Eddie go.

This story is unfortunately typical for many people with brain injuries who try to put in applications for Social Security benefits. Like Eddie, people pay into the Social Security system through FICA and then trust when they become disabled and unable to work, that the government will be there for them.

Although Eddie had received several denials on his Social Security case, he still had the right to appeal and that is just what he intended to do.

The definition of disability under the Social Security law requires that the individual have a medically verifiable disability and the severity of symptoms of the disability keep them from working for a period of 12 months. Social Security defines work as earning of $730.00 per month.

Here are some facts that will help you in the appeals process with Social Security.

- The initial application for disability benefits is an easy process and few people need assistance, in fact Congress has made the Social Security Administration responsible to help new applicants. An application can be initiated by calling the Social Security hotline, 1 (800) 772-1213. It will take approximately 15 minutes to get a live person who will ask you your name, address, telephone number and Social Security number. This representative of SSA will contact the local office on your behalf, who in turn will call you, send an application to your home and arrange for a telephone interview.

- When an initial application results in an unfavorable decision, remember that you have a right to appeal Social Security's decision. Forms can be requested from the local Social Security Administration by telephone, by letter or in person. Although it is not necessary to use a representative, using the help of a knowledgeable claimant's representative will significantly increase the chances of a successful appeal. A claimant's representative can help with the appeal forms, can assist in obtaining medical evidence, can meet with the Disability Determination examiner, who makes the decision in your case and can recommend additional medical testing that can assist SSA understand the level of severity of your disability.

- If the reconsideration appeal results in another unfavorable decision, you have the right to request a hearing before an Administrative Law Judge (ALJ), who is an employee of the Social Security Administration but is an unbiased adjudicator. This Judge has 3 general duties. He

■ *continued on page 2*

■ continued from page 1

understands the Social Security law and regulations and is there to protect your rights in that he insures that you receive a fair hearing, he protects the rights of the citizens of the USA who do not want to pay out benefits to people who are not really disabled and he is there to protect the trust funds, to ensure that individuals with disabilities, who are really disabled, receive favorable decisions. Nation wide about 59% of cases heard by Administrative Law Judges, result in favorable decisions.

Mr. Chavez received denials at both the application and reconsideration processes from SSA. He hired a representative who was knowledgeable in the effects of brain injury. An affirmative case was presented to an Administrative Law Judge in Evanston, Wyoming, which resulted in a favorable decision. Mr. Chavez receives monthly benefits from SSA, is married and has 2 children and is currently doing what he can to tend the children at home while his wife works to add additional support to their family.

If you need assistance with a Social Security problem, you can contact employees at the Brain Injury Association of Utah, (801) 484-2240.

Volunteers Needed

The Brain Injury Association of Utah is seeking volunteers for general office duties; include answering telephones, filing, preparing information packets, and mailers.

For more information, please call our office at 801-484-2240, or email us at biau@sisna.com

Visit our Web Page at: **www.biau.org**
E-mail us Your News or Comments:
biau@sisna.com

Headaches and Brain Injury

By Tamara J. Hauge, Esq.

Medical literature reports that chronic headaches are one of the most common complaints of traumatic brain injury survivors, however, there is much that medical science still does not know about headaches. Doctors report that activated nerves surrounding the skull, blood vessels, and head muscles cause headaches. These activated nerves send pain signals to the brain, thus causing the sensation of a headache. Why the nerves are activated is not entirely understood, nor do we understand the mechanism by which a traumatic brain injury triggers chronic headaches.

What we do know is that chronic headaches can be disabling, and can increase already existing problems of concentration, memory loss and depression caused by a traumatic brain injury. Many brain injury survivors have to cut back on aspects of their job, which cause them stress and increase their headache pain. This can limit a survivor's promotions and raises, or may force a survivor to change employment. Headache pain can make it difficult for a survivor to engage in normal activities such as parenting, recreational and social activities. Students with chronic headaches may have difficulty in school.

Resources available to chronic headache sufferers include the following:

1. **Medication:** Some medications work to prevent headaches, others alleviate the symptoms once a headache has begun. Some medications aid the sufferer to sleep, while reducing the pain. It is important to have a good doctor who can educate the patient by presenting the best options for pain relief as well as indicating if there are unwanted side effects to medications.

2. **Biofeedback therapy:** This therapy trains the headache sufferer to control muscle tension and relaxation, thus reducing the symptoms of headache. A trained technician administers biofeedback as part of a biofeedback therapy program.

3. **Cognitive therapy:** This therapy, provided by a psychologist or counselor teaches stress-management skills and other tools that helps the headache sufferer to deal with situations that cause headaches to become worse.

4. **Chiropractic treatment/massage:** Often a traumatic brain injury survivor has also received a neck injury, which can exacerbate headaches. Chiropractic treatment and massage therapy can eliminate some causes of tension headaches, and alleviate stress. Chiropractors usually teach a patient to engage in a home exercise program that is useful to prevent further muscular problems from contributing to chronic headaches.

5. Some groups which might be useful to those with chronic headaches:

*** The American Council for Headache Education: "ACHE"**
(856) 423-0082 www. achenet.org
"ACHE" has a newsletter, library, support groups, discussion forums and assistance in finding a doctor.

National Headache Foundation:
1-888-NHF-5552 www.headaches.org
This group provides information about headaches through their Website, newsletter, and research.

Don't Get Dead!

Safe Kids Week Focuses on Preventing Brain Injuries

By Cyndi Bemis
Utah SAFE KIDS Coalition

Heads Up! 2002 is the theme of this year's SAFE KIDS Week May 4 - 11, 2002. The Utah SAFE KIDS Coalition and National SAFE KIDS Campaign teaming up to make parents and children aware of the ed to protect children's developing brains from injury.

When a child's brain is hurt, it doesn't heal like a cut or a ken bone, so damage from a crash or a fall can often be manent. And because kids can't recognize risk, it's up to ents and caregivers to keep them safe.

Motor vehicle crashes are the major cause of brain injury d death in children ages 5-14. According to the Brain ury Association of Utah, more than 50,000 Americans will this year as a result of a traumatic brain injury.

The real tragedy in this is that most injuries can be oided. "All it takes is a helmet, a seat belt or car seat to duce your child's risk of brain injury," said Utah Safe Kids alition co-chair Janet Brooks.

During Safe Kids Week, May 4-11, the coalition will the road, going border to border in two caravans

■ *continued on page 7*

Utah SAFE KIDS Coalition
SAFE KIDS Week: May 4th-11th, 2002
Heads Up 2002

Day	Date (May)	Rhonda's Route	Time	Janet's Route	Time
aturday	4th	**Magna** Masonic Lodge 2610 So 8950 W	10:00 - 1:00	**Ogden** Natural Health & Spine (by Fred Meyers) 270 E 12th St	11:00 - 2:00
		Provo (GM) Masonic Lodge 875 W 1850 N - Rt 60	3:00 - 6:00	**Logan** Arctic Taylor Chevrolet 1475 North Main	10:00 - 1:00
Monday	6th	**St. George** Smiths 250 N Bluff	4:00 - 8:00	**Moab** Masonic Lodge 290 So 400 E	3:00 - 6:00
Tuesday	7th	**Cedar City** Smiths 600 So Main	4:00 - 8:00	**Price** Firestation 87 N 200 E	3:00 - 7:00
Wednesday	8th	**Delta (GM)** Broughton Chevrolet 248 W Main	3:00 - 6:00	**Vernal** Prime Time for Kids 1360 W US Highway 40	3:00 - 6:00
Thursday	9th	**Richfield** Jorgensen Ford 1000 S. Main	3:00 - 6:00	**Heber** Health Dept 55 So 500 E	2:00 - 6:00
Friday	10th	**Brigham City** Shopko 747 South Main	4:00 - 7:00	**Park City** WalMart 6545 N Landmark Dr. I-80 Exit to Park City	3:00 - 6:00
Saturday	11th	**American Express** 4315 So 2700 W	10:00 - 1:00	**Davis** Northridge High School 2450 N 400 W Layton, UT 84041	10:00 - 2:00
				Tooele (GM) Smith's 540 North Main St.	10:00 - 1:00

DONATIONS

BECOME PART OF THE BIAU FAMILY

GOLD BAR -

$5,000 & Over

Utah Families Foundation

GOLD NUGGET -

$1,000 & Over

Elaine Clark, Ph.D.
William & Carole Evans
Eisenberg & Glichrist
Soroptimist International of Salt Lake
Tasha Savage
Utah State Employee Charitable Fund

NUGGET - $500 & Over

Primary Children's Hospital
Quinney Rehabilitation Institute
Robert S. Peteuil • Steiner Foundation Inc.
Wheeler Machinery

GOLD DUST - $250 & Over

Sam Goldstein, Ph.D.
HealthSouth Rehabilitation Hospital of Utah
Julie Lester • Perry Financial Group
Phoenix Services
Law Offices of William R. Rawlin
Regency Blue Cross Blue Shield
Rex Neibar • Robert, Robb, Harris & Love
Tamara Hauge, ESQ. • United Concert

$100.00 - $249.99

A & Z Produce • Crown Burger
Alan Davis, Ph.D. • Eisenberg & Gilchrist
Fryer Promotions • Judith Gooch, M.D
Brian Kelm, ESQ., P.C.
MGD Management • G. Barrie Nielson
George W. Pratt • John Speed, MBBS
Sykes & Associates

$50.99 - $99.99

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All charitable donations are tax deductible

Therapeutic Horseback Riding: Changing Lives One Hoof Beat at a Time

By Doug Dusenberry
Director of Courage Reins

Today, most health care professionals and family members of people who have sustained a brain injury recognize the importance of alternative therapies in the healing process. Initially they can augment more traditional rehabilitative therapies and as the person recovers, they may replace them completely.

One alternative therapy that has grown tremendously in popularity around the country is therapeutic horseback riding. Although there is historical evidence that horses have been used to aid in the healing process as early as 100 BC, it did not get it's formal start in this country until about thirty years ago when NARHA was founded.

NARHA, which stands for North American Riding for the Handicapped Association, is the national governing body for therapeutic riding in this country. They set accreditation standards for member operating centers, certify therapeutic riding instructors, and work to educate the public about the benefits of riding therapy.

Today there are over 600 NARHA operating centers, throughout the US, that offer therapeutic riding programs. These accredited centers must meet stringent safety equipment. The instructors have been trained in horsemanship and adapting lesson plans to maximize safety and effectiveness for people with various types of disabilities. If the program offers Hippotherapy, the lessons are taught by a physical or occupational therapist that has additionally certified in therapeutic riding.

The activities that take place at a therapeutic riding center can be very beneficial for people who have sustained a brain injury. Grooming the horse can remind a person that there are others who need their assistance (thus working against the egocentricity that can develop). Grooming also provides an opportunity for the student to work as a team with the riding instructor, volunteers, and the horse thus promoting communication and social skills. In addition to grooming, most programs will teach students about horse care, another activity that definitely promotes memory, problem-solving skills, and a sense of responsibility for others.

Obviously, a therapeutic riding program also incorporates RIDING. The unique three-dimensional gaits of the horse constantly challenge and improve a rider's balance, strength, posture, and coordination. A horse provides an opportunity for someone who may be confined to a wheel chair or walker to move effortlessly around an arena or down a trail. Riding can improve spatial orientation and planning as well, as people learn to negotiate courses or barrels while mounted.

Horseback riding also provides an opportunity to learn a skill that can be used for a lifetime. It is something that the whole family can participate in. Today with Paralympic and other competitions there is no limit to where a student can take their riding.

The best part about therapeutic riding is that it doesn't feel like therapy, it's fun! Because it's fun, students are motivated to continue, unaware of the improvement that's happening continuously. If you or someone you know would like to get involved, you can call NARHA at 1-800-369-RIDE or find them online at www.narha.org for a list of centers in your area. We look forward to seeing you in the saddle.

Simple Pleasures.

Severe spasticity may keep you and your family from life's simple pleasures. It doesn't have to. Now there are new ways to help control even the most severe spasticity due to brain injury or stroke. For more information on spasticity control, contact the Brain Injury Association of Utah, Inc. at 1-800-281-8442, or call 1-800-638-7621, ext. 5986.

Medtronic

HELP!

To individuals with a Traumatic Brain Injury and their families, TBI service providers, Agencies.

The Department of Health has received a federal grant to develop a Statewide Action Plan to help improve TBI services in Utah. The Brain Injury Association of Utah (BIAU) has been involved in the planning of this project and will continue to be involved.

In order to develop this plan we need your input. The survey is the first step in gathering the necessary information. Please fill out the survey with or without the help of another person. The survey can be found on the BIAU website at www.biau.org or call

Richard S. Harward, MS
TBI Project Coordinator
801-584-8529 or email at
rharward@doh.state.ut.us

YOU CAN MAKE A DIFFERENCE

Rehabilitation Services
University of Utah Hospitals & Clinics

Community Rehabilitation Services

Community Rehabilitation Services (CRS) is a unique home- and community-based program designed to meet the needs of patients requiring integrated rehabilitation therapy services on an outpatient basis. Coordinated therapies are provided in the home, school, workplace and/or community.

Diagnoses commonly treated at CRS:

- Brain injuries
- Strokes
- General neurological disorders

Clinical services provided in the CRS program are: *rehabilitation nursing, physical therapy, occupational therapy, speech therapy, social work, and psychology.*

For more information:

Community Rehabilitation Services
Sugar House Health Center
1138 East Wilmington Avenue
Salt Lake City, Utah
(801) 581-2221

Community Rehabilitation Services is the only CARF Accredited program for Home- and Community-Based Rehabilitation (Adult) in the Intermountain West.

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holding free car seat checkpoints. Utah's Masonic temples are co-sponsoring the event, which will include free car seat giveaways and bike helmets available for a $5 donation. "The most important thing we can do is personally take our safety message to Utah parents," said Brooks. "We also need to get safety equipment like car seats and bike helmets into the hands of the people who need them. That's what our caravans will do."

The event will feature plenty of activities for kids, including a 9-1-1 simulator provided by Safe Kids sponsor State Farm Insurance. "The simulator is a great tool to train kids to call 9-1-1 in an emergency," said State Farm Eric Olson. 'The child picks up the phone, dials the number, and is connected to a computer program that will walk him/her through a simulated emergency."

There will also be presentations from brain injury survivors as well as puppet shows, bike rodeos and safety videos available in English and Spanish.

New and Renewing Members

Leona Bull • Debra Elliot • Sarah Griffiths
Edna Henke • Judith Holt • Paul Halleck
Jeffrey B. Hatch • Dawn Hill • Pat Hill
Amy Krough • Thomas W. McCloud
Carol Millikan • Bonnie Meyers • Nancy Murray
Gerald Nebeker • Newbold, Ph.D. & Associates
Options for Independence of Logan • Phoenix Services
Jamie Shaw • John Speed • Carol Tidwell
Florence Voorheis • Terry F. Ward • Sandy Wright

2002 BIAU Events

May 4th - 11th
Brain Injury Awareness Week

Heads Up 2002
Use Your Head, Don't Be Dead

Statewide Prevention Event
In conjunction with SAFE KIDS Coalition

May 18th
8th annual 5K Run, Walk & Roll

When: Saturday, May 18, 2002
9:00 a.m. Sharp
Where: Memory Grove
135 East North Temple, SLC

Please arrive between 7:30 - 8:30 a.m. to pick up registration packet

Race begins and ends at entrance of Memory Grove

****

October 10 - 11
13th Annual
Family & Professionals Conference

When: Thursday - October 10th &
Friday - October 11th
Where: Marriott Hotel, Provo, Utah

For additional information regarding these events, please our office at 801-484-2240 or 800-281-8442

DEWSNUP, KING
& OLSEN

TELEPHONE
(801) 533-0400

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DOUGLAS H. PATTON
PAUL M. SIMMONS

Program

Each issue of "Making Headway" will spotlight a former student from the Return to Work Program. The article will include remarks from student, family member, and employer.

TheBrain Injury Association of Utah held an Open House on January 11, 2002, to recognize Alan Hansen as the 100th student of its Return to Work Program. Alan has a great testimony of how the program has changed his life and that of his family. He was a successful landscaping supervisor for the City of Layton. Happiness and dreams were suddenly shattered for Alan and Tricia. In 1993, Alan began having severe headaches. Many tests later, doctors found that Alan's headaches were the result of pressure on the brain caused by a malformation of the skull at birth. This condition was quickly impairing Alan mentally, physically and emotionally. He underwent two delicate surgeries in a desperate attempt to recover, but they were unsuccessful and Alan subsequently lost his job. Alan went downhill rapidly and became unable to perform the simplest tasks. He soon fell info severe depression and hopelessness. Nothing seemed to matter anymore; he thought he was going to die. Meanwhile, his wife Tricia felt despair as she was helplessly witnessing Alan become a mere shadow of the husband and father he once was. But they were committed to make it through together. Alan had a new dream: going back to work. With determination, Alan went through various therapies with more or less success. In 2001, he finally found the support he needed. The State Office of Vocational Rehabilitation referred Alan to the Brain Injury Association of Utah. At the Brain Injury Association of Utah, Alan found a new home. He was not alone anymore as he worked through the Return to Work Program. He slowly regained his self worth and realized that even if he had lost many skills, he still had much to offer. All he needed was to be given a chance. With the coaching and help of the Brain Injury Association of Utah, Alan was rehired by Layton City in a similar position to what he left three years before. For the last four months, the Brain Injury Association of Utah has continued to coach and guide Alan to ensure that he successfully retains his position. Alan is proud of his accomplishments and keeps gaining confidence as time goes by. He and Tricia feel that without the Brain Injury Association of Utah, Alan never would have returned to employment and to living a more meaningful life.

LDS Hospital

Brain Injury Support Group, *David Ranks, Ph.D.
8th Avenue C Street, Salt Lake City, UT 84143
(801) 408-5400, Call for Date & Time

Salt Lake Regional Medical Center

Moreau Building Auditorium
Brain Injury Support Group, *Kathryn Waddell
1002 E. South Temple, Salt Lake City, UT 84102
(801) 350-4290, Call for Date & Time

South Davis Community Hospital

Brain Injury Support Group, *Louise Jarvis / Shelly Lanham
401 South 400 East, Bountiful, Utah 84010
(801) 295-2361, Meet 1st Tuesday of Month 7:00 p.m.

Sugarhouse Health Center

Brain Injury Support Group, *Lisa Schweitzer/ Michelle Corless
1138 E. Wilmington Avenue, Salt Lake City, UT 84106
(801) 581-2221, Meet 4th Tuesday of Month 7:00 p.m.

Utah Valley Regional Medical Center

Brain Injury Support Group, *Rosemary Robertson
1034 North 500 West, Provo, UT 84604
(801) 373-7850 ext 2791, Meet 2nd Tuesday of Month 7:00 p.m.

Options for Independence of Logan

Brain Injury Support Group, *Teresa Christiansen
1095 North Main, Logan, UT 84321
(435) 753-5353, Meet 4th Wednesday of Month 7:00 p.m.

Department of Human Services of Richfield

Brain Injury Support Group, *Dian Chivers
201 East 500 North, Richfield, UT 84701
(435) 529-0153, Call for Date & Time

Uintah Basin Medical Center - Roosevelt

Brain Injury Support Group, *Glen & Sheila Fenn
250 West 300 North, Roosevelt, Utah 84066
(435) 454-3920. Call for Date & Time

Remember You Are Not Alone!

DISCLAIMER: Brain Injury Association of Utah does not support, endorse or recommend any method, treatment or program for brain injured persons. We endeavor to inform, and believe that you have the right to know what help is available.

12th Annual Family & Professionals Conference

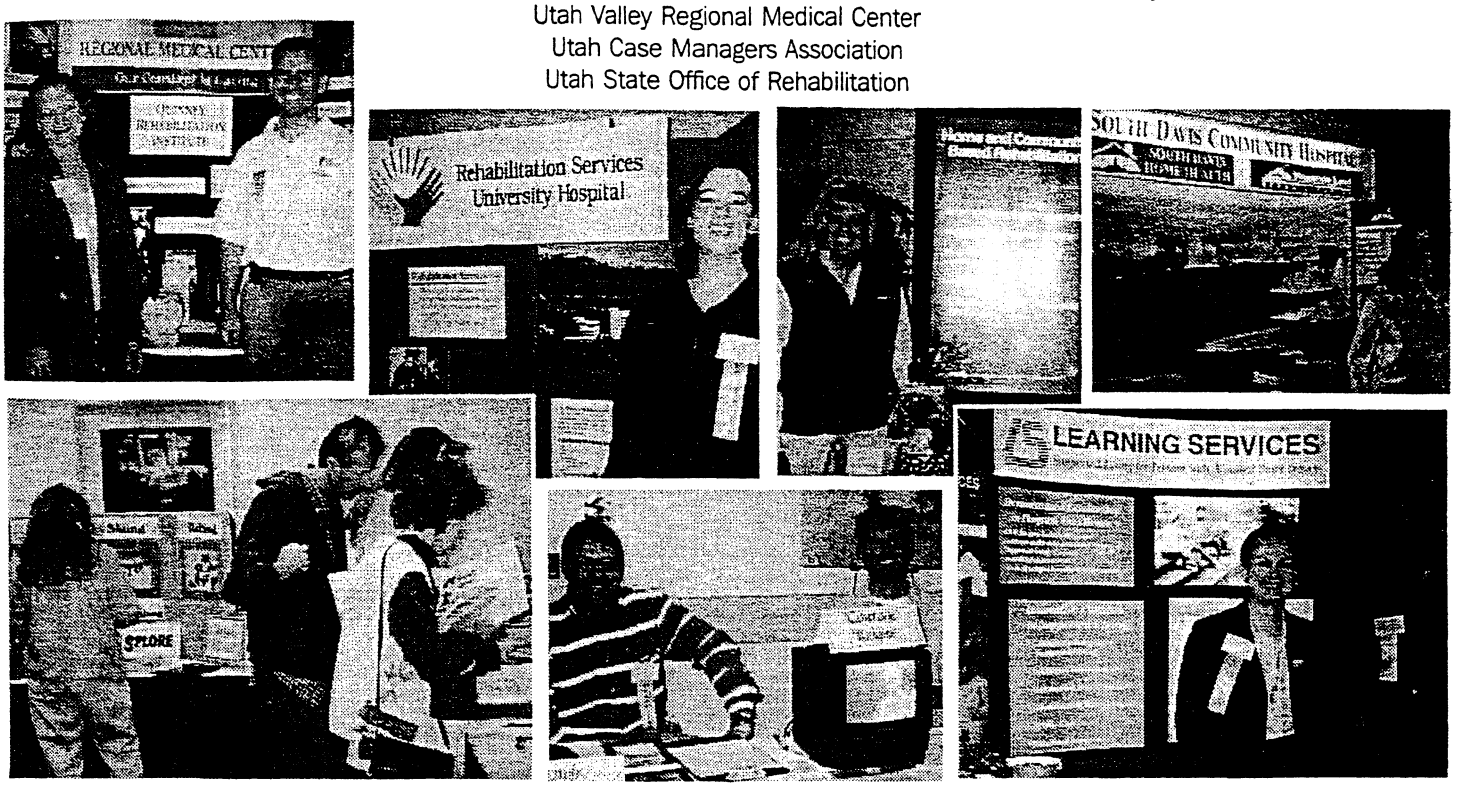
The Brain Injury Association of Utah held the 12th annual Family & Professionals Conference on October 11-12, 2001 at the Marriott Hotel in Provo, Utah. The conference provided information to individuals with brain injuries, family members, educators, rehabilitation counselors and medical professionals. The conference was co-sponsored by the Division of Services for People with Disabilities, Utah Department of Health - Violence & Injury Prevention Program, Utah State Office of Education, and Utah State Office of Rehabilitation Services. Major contributors for our conference was the Centre for Neuro Skills, Law Firm of Eisenberg & Gilchrist, Learning Services Corporation, and the Rehabilitation Services University of Utah Hospital. Keynote speakers were Allan Bergman, President & CEO of the Brain Injury Association of America, Randall Evans, Ph.D., President & CEO of Learning Services Corporation, Chris Merkley, M.D., physician and parent of daughter with a brain injury.

There were 315 in attendance. Including conference committee members and speakers. The conference was well organized, informative, and a great way for families and professionals to share information, socialize and learn about relevant topics related to traumatic brain injury. Our thanks go out to the Family Conference Committee, staff, volunteers, speakers, and exhibitors who helped make the conference a success.

KEYNOTE SPEAKER
Allen Bergman
President/CEO
BIA-America

KEYNOTE SPEAKER
Dr. Chris Merkley

Centre for Neuro Skills - Courage Reins Therapeutic Riding Center - Gentiva - Rehab Without Walls
Learning Services Corporation - Quinney Rehabilitation Institute - Salt Lake Regional Medical Center - Rehabilitation Services
University of Utah Hospitals & Clinics - Utah Hyperbaric Service - South Davis Community Hospital
Utah Valley Regional Medical Center
Utah Case Managers Association
Utah State Office of Rehabilitation



Duval Hansen Witt & Morley, P.C.

Attorneys at Law

Practice Emphasizing

TRAUMATIC BRAIN INJURY

- Member BIAU
- Member Utah Trial Lawyers Association
- Experience in Brain Injury Cases
- Experience with Nationally Renowned Experts
- Experience with Facilities Providing Latest and Best
- Diagnostic Services in Country, i.e. Functional MRI & SPECT Scans, PET Scans, QEEG

1-801-756-7658

All-Terrain Vehicles

Taken from the summer Safety For Children brochure
Written by Marilyn Lash, M.S.W. and Roberta DePompei, Ph.D.

These vehicles are appealing, but dangerous for children. Although they look safe and stable because of their large soft tires, riders are injured when the driver loses control or is thrown off, the vehicle rolls over or collides with something. A three-wheeled ATV is more unstable that a four-wheeled ATV.

FACT: Two-thirds of ATV-related injuries have occurred to children under 16 years old.

FACT: Injuries to the central nervous system and the head are the major types of severe injuries involving ATV's.

Checklist for parents on ATV safety:

- Model safe behaviors by always wearing a helmet with face protection and protective clothing (trousers, boots and gloves) if you are riding an ATV
- Children under 14 years should NOT operate any ATV
- Use the buddy system; never ride alone.
- Use moderate speed and only ride during daylight.
- ATV's are designed for one person only; never take passengers.
- Use four-wheeled, not three-wheeled ATV's for better stability.

Brain Injury Association of Utah, Inc.
1800 So. West Temple, Suite 203
Salt Lake City, UT 84115

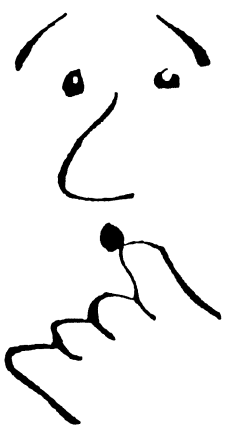
Due to the cost of mailing this quarterly newsletter to you, it is extremely important for you to notify our office or e-mail us at biau@sisna.com with any change of address, or if you no longer wish to receive this publication.

DATED MATERIAL.
PLEASE DON'T DELAY

Possible Changes after a Brain Injury

Physical Changes

- Motor coordination
- Hearing and visual changes
- Spasticity and tremors
- Fatigue and/or weakness
- Taste and smell
- Balance
- Mobility
- Speech
- Seizures



Possible Changes after a Brain Injury

Personality and Behavioral Changes

- Depression
- Social skills problems
- Mood swings
- Problems with emotional control
- Inappropriate behavior
- Inability to inhibit remarks
- Lack of response to social cues
- Problems with initiation
- Reduced self-esteem
- Difficulty relating to others
- Difficulty maintaining relationships
- Difficulty forming new relationships
- Stress, anxiety & frustration

Possible Changes after a Brain Injury

Thinking Changes

- Memory
- Decision making
- Planning
- Sequencing
- Judgment
- Processing speed
- Problem solving differences
- Persistence
- Organization
- Self-perception
- Perception
- Inflexibility
- Thinking

DID YOU KNOW?

⇒ Over the past 12 years, mortality from brain injury has exceeded the cumulative number of American battle deaths inclusive of all wars since the founding of the Republic.

⇒ Traumatic Brain Injury (TBI) is a silent yet serious epidemic currently leaving 5.3 million Americans with disabilities. This represents over 2% of the US population; 40,000 victims in Utah alone!

⇒ 50% of brain injuries are caused by vehicle crashes, 26% by falls.

⇒ In September 2000 alone, 8600 children under the age of 15 suffered a brain injury from scooter accidents... almost 300 children per day!

⇒ Every 7 minutes, someone dies of a brain injury.

⇒ One death every day and one brain injury every four minutes can be prevented by the use of helmets in recreational activities, including skiing and biking.

⇒ 80% of brain injury victims end up in a divorce.

⇒ 75% of persons with TBI who return to work will lose their job within 90 days if they do not have supports.

⇒ The estimated lifetime cost for each survivor of a severe brain injury exceeds $4 million.

⇒ According to a study conducted by The National Foundation for the Brain, the cost of brain injury in the United States was $48.3 billion in 1992. We estimate that this figure may be substantially higher today.

You can make a difference. Please help!

BRAIN INJURY ASSOCIATION OF UTAH, INC.
Phone: (801) 484-2240 · Toll Free: (800) 281-8442 www.biau.org

CLUES TO IDENTIFYING A POSSIBLE BRAIN INJURY

Behavioral

Wanders off/runs away
Impulsive (acts without thinking)
Reduced self-esteem
Repeated invasion of personal space
Short fuse-unable to control outbursts
Difficulty maintaining relationships

Personality

Denies deficits
Irritable
Egotistical
Doesn't listen
Asks a lot of questions
Argumentative
Manipulative
Appears unmotivated
Moody – Laughs or cries easily
Depressed
Face shows little or no emotion
Appears angry

Social

Doesn't recognize "personal space"
Inappropriate social interaction
(overly formal, overly friendly)
Interrupts conversations
Fabricates stories/lies
Poor eye contact
Inappropriate conversations
(sex, drugs, alcohol abuse, etc.)
Goes off on tangents

Cognitive

Easily distracted
Seems to "space out"
Difficulty understanding
Difficulty with reality
Seems confused
Poor memory
Decreased safety awareness
Slow to answer questions
Difficulty organizing

Verbal

Poor speech
Monotone
Vulgarity/Swearing
Talks too loud or too soft
Difficulty "finding" words
Broken speech

Physical

Fatigue and/or weakness
Spasticity and tremors
Motor coordination
Speech difficulties
Seizures
Balance
Mobility
Taste or smell changes

TRAUMATIC BRAIN INJURY FACTS

Do We Have a Future??

Posted By: allister <

>

Date: Monday, 23 June 2003, at 5:05 p.m.

Dear Members,

For some, these questions may be of little importance, for others it may mean everything.

When we are healthy and self supporting, there are many choices/options open to us.

Once we have an injury, that seems to change dramatically. Those of you who have someone with you, to help, understand & support you, I think are very fortunate.

For those who have chosen or are forced to live alone (there are just so many reasons for choice or no choice), do you think your quality of life might improve if you had the chance to share exspenses if you found someone "suitable" and wouldn't interfere w/your lifestyle a great deal.

What do you think your chances would be of being able to FIND someone "suitable" w/o undue stress? (We hear all these horror stories)

Do your injuries create more problems as each year passes?

Do you worry about how you are going to manage, both physically & fianancially?

What if you were unsuccessful in a lawsuit & it is close to being a "early death sentence" for you, unless someone will help you?

If your situation is "OK" for now, do you constantly worry about what's ahead?

Does your city, state, province, have any organizations that have any projects enforce, that would screen people w/similiar problems & needs and therefore make it easier to find a suitable solution? (even if it's a trial form of arrangement)

Do you wish something would be in place that would promote indedependant living w/o leaving us on the verge of poverty all the time?

If they did, would anyone be interested??

I hope you don't find these questions too depressing or morbid, but when faced w/cold realities, one has to consider alternative lifestyles.

I know, by reading so many of the posts, that life isn't all that rosey for many of us & that doesn't include what our injuries inflict upon us.

For those of you who would like to comment, please do. I always wonder if others

C. Shallice & Warrington (1969)

Subject: K.F.: left parietal-occipital fracture

normal I. Q.
memory span = 1 digit!

Interpretation: severely damaged STS

D. Korsakoff's Syndrome

ìKorsakoff syndrome, or Korsakoff psychosis, involves impairment of memory and intellect/cognitive skills such as problem solving or learning, along with multiple symptoms of nerve damage. The most distinguishing symptom is confabulation (fabrication) where the person makes up detailed, believable [or not] stories about experiences or situations to cover the gaps in the memory.î (Medical HouseCall)

http://www.ami-med.com/mhc/top/000771.htm

Every fifteen seconds someone in the U.S. suffers a brain injury. Every five minutes, one of those people will die. Each year 52,000 people die of traumatic brain injury (TBI). Among all types of injury, traumatic brain injury is most likely to result in death or permanent disability. The life of a traumatically-brain-injured-person is a lonely, confusing and terrifying one. Imagine one day waking up and not being able to talk or walk, and perhaps, being blind but no one knows it. You are imprisoned in your body, unable to communicate your thoughts and not remembering why you are here. What if you will never be able to remember what happened to you because the event that caused your injury was not registered in your brain and can never be retrieved? What if your long-term memory is gone forever? What if you suffer from short-term memory loss and cannot remember what day it is or what you had for breakfast? You may be able to understand what is going on around you but unable to communicate due to the brain being unable to function. As a result, some people will mistake your brain injury with mental incapacity. Yet you feel like the same person inside as you were before the injury. But you are not! How long will it take you to become aware of this? This may be the worst-case scenario for some brain-injury persons but even mild brain injury can change your life forever. Because each person has a unique brain, no two injuries are alike. Further, the effects of brain injury are not always visible or diagnosed at the time of injury. They may range from physical, emotional or social changes to experiencing all three simultaneously. Doctors may speculate about the effects of a severe head injury, based on the extent of trauma to the brain and the location of the damage. But they cannot tell you accurately what your life will be like because this will depend on time and whether you can perform tasks as you did before. This may not be known for weeks or even years. In a matter of seconds – no matter how safe you think you might be - life, as you know it, can be radically changed forever. Most people do not want to know the realities of traumatic brain injury or how prevalent it is in the United States alone. Nevertheless, it can dramatically affect your life in a split second if you or someone you love is injured. Whether driving in your car, innocently working out at the gym or just being at home – a careless act or accident can change your life forever – or end the life of someone you love. (see) If you have not been affected by knowing someone with a brain injury, you probably haven't become informed about its seriousness. Please read and learn. The Centers for Disease Control has estimated that each year 260,000 people are hospitalized with a traumatic brain injury. Permanent injury results in 70,000 to 90,000 of these cases. The costs of acute care, rehabilitation, chronic care and indirect injuries impose an annual economic burden of $37 billion in direct and indirect costs. Each of us thinks, "This will not happen to me." But in the time it takes to read this paragraph, one person will have sustained a traumatic brain injury. The sad fact is that after one TBI, the risk for a second injury is three times greater, and after a second, the risk of a third is eight times greater. It takes just a few seconds to receive an insult to the brain. A child falling off a bike; a parent shaking a crying baby; a diving accident; a car wreck; a motorcycle collision; all these seemingly simple accidents can change your life forever if the resulting injury is to the brain. Everyone, no matter how young or old, should be educated on traumatic brain injury and the ripple effect it has on all those involved, especially the victim's family. The world of a traumatically-brain-injured person is a scary one. We want you to remember that no matter how tough it gets,

There is a national Brain Injury Association at 105 Alfred Street, Alexandria VA 22314. (Telephone 703-236-6000 or toll free 800-444-6443.) There are Brain Injury Associations in 48 states. There are many support groups operating in towns all across the country. All of this has happened since 1980 and the associations and support groups provide an excellent resource for families to access information about brain injury. TBI is a long journey - but you don't have to trudge it alone. There are thousands of people who experience this world daily - a world they were thrust into without their consent. It does not mean that your life is over but it does mean that your life has changed. You will have to learn how to live in this new world and so will your family and friends. There is help. Please read on. This Page is courtesy

Personal Iinjuries On Plaintiff As Far Known

(1) Left Parieto-Occipital Skull Fracture

(2) Right Proximal Humeral Epiphyseal Fracture

(3) Left Proximal Femoral Head Fracture

(4) Left Proximal Fibular Fracture

(5) Left Distal Tibial Fracture

(6) Scalp Lacerations

(7) Extensive Pulmonary Contusions Both Lungs

(8) Multiple Opaque Densities Over Left Abdomen

(9) Sub Capsular Hematoma

(10) Multiple Lacerations On Head And Face

(11) Left Temporal Laceration Perla

(12) Put Into Traction For Some Of The Fractures

(13) Physical Therapy Was Needed For Patient To Walk Again

many other injuries in the medical reports

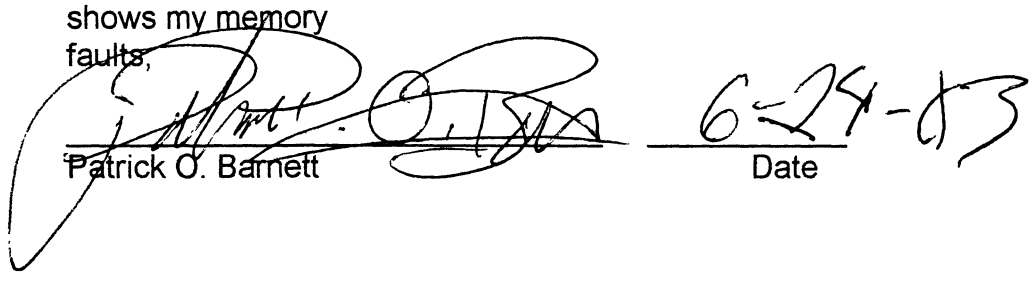
Patrick O. Barnett

6-24-03

Date

Notice Leaving A Gas Station Without Payment

I have left many gas stations forgetting to pay numerous times here attached is a notice
from a investagtor the gas station chevron at aprox. 3500 south 3200 west in west valley city
i have done this many times a man there by the name of shawn knows me by name because of this
and is due from my forgetfullness and memory issues from said brain injuries described in the calim
of this case, another gas satation is at 4700 south and 40th west in kearns where i have done this also
and the sherriffs department has called all the above has been paid but this also shows my memory
faults,



Patrick O. Barnett

6-24-05
Date

Collins
Associa

Bonded

May 29, 20(

Patrick Ba
3253 Wes
West Val

, conduct an investigation of a drive off

your motor vehicle, licerse plate
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Re: I

Dear Mr

ıthia at (801)224-2518 within three

Our offic
involving

an investigator may contact you at

According
number 75
paying for

In an effort
(3) days of

If we do not hear fro
your place of residen

5TH Time Tonight
GPS
PAY
FOR

Sincerely,

Kim Collins

KC:cc
Enclosure

[28-003]

EMAND OF YOU DOES NOT CRIMINAL PROVISION.

narize significant
igs from interview and
e assessment.

Identifying Information (age, marital status, race, sex, employment status. Referred by? Referred for?)

Chief Complaint

History of present illness (Current symptoms, signs, duration, precipitating factors).

Past Psychiatric History (Where, with whom, diagnosis, treatment. Include duration, medications, outcome, hospitalizations, suicide attempts, assaults, substance abuse).

Family History (Significant psychiatric history, substance abuse, legal, occupational, home atmosphere, medical history).

Social History (Developmental history, educational history, occupational history, marital history, children, social supports, premorbid personality, strengths and weaknesses).

Medical History (Illnesses, operations and accidents; medications; allergies; review of systems; Is Physical Exam indicated?)

Mental Status Exam (including cooperation, appearance, speech, behavior, mood/affect, thought processes/content, cognitive function, insight and judgment, motivation).

Formulation (summarize findings that support diagnosis).

Diagnosis (including 5 axes).

Plan (medication options; medications started and rationale; other therapies indicated; date of next med. follow up and with whom.

Prognosis.

Signature and title of M.D.

PSC: Curtis Budge

1. Identifying Information: Patrick is a 35-year-old male who lives with his wife, his three step-children and his daughter. He works for his dad in a graphics shop.

2. Chief Complaint: "I'm anxious and depressed."

3. History of Present Illness: When client was nine years of age, he was involved in a motor vehicle accident where he was a pedestrian on his bike and he was hit by a car. He was in a coma for an undetermined length of time (client does not remember), and since then he has suffered nightmares of the accident, they are sometimes almost nightly, and intrusive thoughts one to four times a month and distress at reminders of this accident. I spoke with his mother on the phone who states the client was a "fine, well-adjusted boy until the accident," he had no problems with school before the accident, but he had many academic problems with school following the accident. He was in a body cast for a year, and was socially ostracized by many of the other children teasing him and trying to trip him, and he was also held back a grade in school. The mother also commented that the patient was never anxious before the accident and that he has always been a highly anxious child since the accident.

Patrick complains of periods of depression where he "just gets depressed," these periods do not happen consistently for weeks, but are mostly a matter of days, other days he is "the happiest person in the world." During depressive days, he has poor energy, hypersomnia and loss of interest in things. During his energetic days, that do not last longer than three days, he has periods of excessive energy but no racing thoughts, pressured speech or impulsivity. He also describes rushes of anxiety that last from 10 to 20 minutes in which he feels lightheaded, anxious, feels his heart racing. These happen four to five times per week and he does worry about their reoccurrence. He has had these for about 7 years. Currently he denies sleep disturbance, his appetite is fine, he says his memory is good. He denies thoughts of death, suicidal ideation and crying spells, loss of interest or depressed mood currently. The stressors in the last year include working, fighting for the custody of his daughter and financial stressors.

VALLEY MENTAL HEALTH

11/05 PSYCHIATRIC EVALUATION

Date 12/16/17

Actual Clock Time 3:00 pm Time Spent 60 min

Client Name Patrick Barnett

I.D. Number

Unit 11350 West Valley

narize significant
igs from interview and
e assessment.

Identifying Information (age, marital status, race, sex, employment status. Referred by? Referred for?)

Chief Complaint

History of present illness (Current symptoms, signs, duration, precipitating factors).

Past Psychiatric History (Where, with whom, diagnosis, treatment. Include duration, medications, outcome, hospitalizations, suicide attempts, assaults, substance abuse).

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Plan (medication options; medications started and rationale; other therapies indicated; date of next med. follow up and with whom.

Prognosis.

Signature and title of M.D.

4. Past Psychiatric History: Client was seen by a psychiatrist after the car accident, but he does not remember the outcome. He denies psychiatric hospitalizations or prior treatment. Legal problems include getting a speeding ticket. He denies drug or alcohol abuse. He denies any suicide attempts or assaults. Four months ago when he was tested by the department of disability determination, he states that his I.Q. was found to be 79.

6. Social History: In speaking with the mother, client was "a normal child" as far as scholastic performance and social skills until age 9 when he had this motor vehicle accident. He had to be in a body cast for a year and suffered teasing by his peers. He was born and raised in Utah. He has two sisters, one older and one younger. He dropped out of school in eighth grade and states his performance was very poor. He was married the first time at age 18 for 10 years and has two daughters, one who lives with him and the other one who lives with his former wife. He remarried again at age 30 and currently lives with his wife and her three children. He has had a hard time maintaining employment. He has had several jobs working in collections, telemarketing, construction, and as a mechanic. He is currently working for his father who has a graphic design shop and the client works under very close supervision and does simple tasks. The mother adds that the client has always been motivated and wishes to work, but has problems with concentration and problem solving which interfere with his ability to work.

7. Medical History: Allergies include allergy to codeine. He is taking no current medications. He denies over-the-counter medications. He denies liver or kidney disease. In addition to his head injury at a young age, he had two concussions, one each at 16 and 18, both as a result of motor vehicle accidents. He has also had an appendectomy and gall bladder surgery.

8. Mental Status Exam: Patrick is alert and he is oriented to the day of the week and has the date wrong by one day. He scored ~~25~~ 27 out of 30 on the ~~MMSE~~ MMSE with deficits in items. At five minutes he was only able to remember 1 out of 3, and he could not correctly repeat the phrase "no ifs, ands or buts." He notes some difficulties with word

Barnette.d00

VALLEY MENTAL HEALTH

11/95 PSYCHIATRIC EVALUATION

Date _____

Actual Clock Time 3:00 pm Time Spent 60 min

Client Name Patrick Barnett

I.D. Number _____

Unit 11350 West Valley

imarize significant
ings from interview and
ke assessment.

Identifying Information (age, marital status, race, sex, employment status. Referred by? Referred for?)

Chief Complaint

History of present illness (Current symptoms, signs, duration, precipitating factors).

Past Psychiatric History (Where, with whom, diagnosis, treatment. Include duration, medications, outcome, hospitalizations, suicide attempts, assaults, substance abuse).

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Plan (medication options; medications started and rationale; other therapies indicated; date of next med. follow up and with whom.

Prognosis.

Signature and title of M.D.

finding. His thoughts are extremely vague and notable for lack of historical detail. He has obvious memory difficulties. He is casually dressed and clean, but his shirt is open down to his belt and he seems unaware of this. He does not have a coat and it is 33 degrees outside. His affect is blunted and the client appears genuinely puzzled at times when I ask him for more specific detail regarding his symptoms and history. His thoughts are concrete. His interpretation of proverbs is concrete. He appears older than stated age. His mood is anxious and depressed. He has good eye contact and is pleasant and cooperative. He does not appear to be distressed by his memory loss or inability to verbalize specific details about his symptoms or history.

9. Formulation: Patrick is a 35-year-old male who is exhibiting symptoms consistent with a head injury and also some residual symptoms from his accident at age 9.

10. Diagnosis: DSM IV
    Axis I: 1. Mood disorder (anxiety, depression), secondary to a medical condition.
    2. R/O panic disorder.
    3. Symptoms of post-traumatic stress disorder.
    4. R/O dementia.
    Axis II: Deferred.
    Axis III: History of three head injuries.
    Axis IV: Difficulties with occupation and financial stressors.
    Axis V: Current GAF: 50

11. Plan:
    1. The client's main concern is anxiety and nightmares and panic attacks. Therefore we will try Paxil 10 mg po q am x 1 week, then increase to 20 mg thereafter.
    2. Follow up with me in one month.
    3. Obtain release of information and get results of psychological testing from department of disability determination.

12. Prognosis: Guarded.

STS

Joan Magill, APRN-PP

Barnette.d00

Date 12/18/97

Actual Clock Time 3:00 pm Time Spent 60 min

Client Name Patrick Barnett

I.D. Number

Unit 11350 West Valley

VALLEY MENTAL HEALTH

PSYCHIATRIC EVALUATION

VALLEY MENTAL HEALTH

5965 South 900 East, Suite 430
Salt Lake City, Utah 84121
TAX PAYER ID NO. 942938348

BILLING INVOICE

FOURTH PARTY STATEMENT

INVOICE DATE: 6-23-05 UNIT: 360 SERVICE DATE(S):

AGENCY OR PERSON REQUESTING: Patrick Barnett

ADDRESS:

PATIENT OR NON-CLIENT NAME: Patrick Barnett

VMH ACCOUNT NUMBER: 0777490

SOCIAL SECURITY NUMBER:

VMH ACOUNTING
NGS LEVEL: —
NGS ACCOUNT:
A/R ACCOUNT:
VMH CONTACT:

SERVICE	RATE	NUMBER OF HOURS	FEE
☐ EVALUATION	$133.00 per hour		$
☐ CONSULATATION	$110.00 per hour		$
☐ CLIENT ADVOCACY	$110.00 per hour		$
☐ CRISIS	$110.00 per hour		$
☒ COPY RECORD	$10.00 plus $0.50 per page	3 pages	$11.50
☐ TREATMENT SUMMARY	$40.00		$
☐ OTHER	$		$
	TOTALS:		$
Make Checks Payable to VALLEY MENTAL HEALTH		PAY THIS AMOUNT	$11.50

OTHER INFORMATION

STAFF COMPLETING REQUEST: S. Edlund

DATE COMPLETED: 6-23-05

LIST OF ATTACHMENTS SENT WITH THIS FORM: psychiatric evaluation

PLEASE PRINT OR MAKE TWO COPIES: FIRST COPY – GIVE TO RESPONSIBLE AGENCY / PERSON
SECOND COPY – SEND TO PATIENT ACCOUNTS OFFICE

WITNESS STATEMENTS FOR PATRICK BARNETT

To the recipient of this letter,

I have made this letter to inform you of the mental and physical condition of my uncle and best friend Patrick Barnett. Over the years I have seen Patrick in good times and bad. In the years I have known Patrick I have noticed obvious physical and mental problems that he has had to deal with for even longer than I've been alive.

I have seen him try to perform simple sporting games such as baseball, basketball, or even playing catch, but have to take timeouts every few minutes to rest because of the pain he is feeling. The next day after playing a simple game of catch, he is extremely sore and has a hard time performing his normal tasks for the day.

I am sure the more frustrating thing for Patrick is his mental problems. Besides the stress and anguish he has felt for not being able to do simple everyday tasks without being in pain, he also has memory problems that are hard not to notice. He has called me on several occasions asking me for a phone number or and address that I have already told him several times before but he could not remember what it was or even where he wrote it down at. I talk about memories from the past with him and he has absolutely no clue what I am talking about. He has actually called me and forgotten the reason why he called. He has trouble learning new things and gets frustrated because he can't get the hang of it.

He has shown me several scars on his body including his head, what If only there was a stop sign on that corner where he was hit he would not have had all the problems I have noted above. I have been to the spot where he was hit. I am no safety inspector but I can obviously tell that no one can see around that corner driving on that road.

This is my point of view on the subject at hand. Personally, I do not think there is a price tag you can hang on all Patrick has been through and lost. I know he deserves better than what he has had, and I just pray something is done to that area of the city to secure safety so this does not happen to someone else.

Dennis Warenski

Elizabeth Barnett
Wife of Patrick Barnett
3253 South Westgene Circle
West Valley City, Ut. 84119

JUNE 23, 2003

I have know Patrick since 1982. We married in 1983. Within a year after we were married it was apparent to me something was wrong. Patrick had previously told me that he was in an accident when he was 8 years old. I began asking him questions but he was reluctant to say too much. He would just say he didn't like to talk too much about it.

I began asking him more questions because things began happening that were frightening to me. He began having frequent nightmares in which he spoke out loud. Cursing, thrashing, locking the bedroom door, at one time even hitting me on the bridge of my nose bruising it, along with my eye. I also saw in his personality, mood swings, in which he could become angry at the drop of a hat.

He can have a conversation with you in which he will sound very intellegent, but often says a few words out of context. Patrick can do more complex task such as work on computers and cars. The problem is he is too inconsistent, not in an ordinary way like you and I, but he will forget simple or even harder task. Sometimes relearning it all together. Sometimes I ask him to wait awhile and see if he remembers.

In the beginning when I first noticed these things, I asked him if he received any head injuries from his accident, he said yes. Then I asked if he has seen anyone for his nightmares or memory problems. He said no. So I asked him to please see someone because I could see his suffering, plus it frightened me. After asking him a couple of times he finally went to see a phsycologist. They diagnosed him with P.T.S.D.,which they explained had a lot to do with his outburst of anger and nightmares. They said he also had short term and long term memory loss due to his various skull injuries.

The therapist led him into opening up more to face his repressed memories of the accident and also put him on medication. This also led him to ask more questions of his family members and various neighbors and friends that were familiar with the accident. This also made him angrier over the whole thing making him realize that it could have happened to any other child, now and in the future.

Patrick to this day has problem seeing any physician. Over the years I have known him to yell, curse, and even throw furniture around when he goes to recieve a shot, get stitches, or panic over recieving an operation. He has also hit people trying to help him and has thrown a glass of water on someone.

The accident has also left him with a pin in his hip. He has pain in his leg and hip everyday, which sometimes causes him to need the aid of a cane. He has been told by his Orthopedic Surgeon that one day he will probably need a hip replacement. When he's not hurting too bad he can play ball or run, but he hurts bad at least three days after.

We have both learned a lot in the past 11 years, some of which he has forgotten, that has caused pain to a lot of us. Patrick has suffered from this for way too long. Hopefully, this can end soon and we can start a new chapter that can help put this pain behind us all.

Elizabeth Barnett
Wife of Patrick Barnett

June 25, 2003

To Whom It May Concern:

My name is Michelle Wenger; I am Patrick Barnett's sister.

I was asked to write a letter concerning Patrick and his state of being after the terrible accident he was involved in as a child. I was a young child myself only age three at the time. I don't remember much of the accident itself, although I remember Patrick being in a full body cast and in a very tall (hospital) bed for a very long time.

As far as the long-term problems that Patrick has had to endure, they include many, most of which I am not aware of, as I don't live with him. Although what I am aware of and have seen over the years is a lot of forgetfulness, thinking that he had told me about a certain topic or event, when I had in fact not heard him speak of that topic or event before. I know he has had to go through a lot of physical pain as well, which then brings the emotional pain from situations like not being able to participate in sports or activities that a typical person of his age should be able to enjoy. Even family events can be a painful experience for him not being able to be a part of the physical activities.

I am also aware of the fact that his memory is not satisfactory. A most recent example would be the following story. Our parents, a nephew and myself, had broken down in our vehicle. Patrick left our brothers house to come and pick us up, only a two-mile drive. After he picked us up to now take all of us back to our brothers house, he headed the right direction but could not remember how to get back to our brothers house that he just recently had left. It took 20-30 minutes of driving in circles. Then it so happened that our Mother found the address and we got to our destination. Patrick was trying his hardest to remember where he had just come from and he could not remember, even though he had been to that address many times before. This type of memory loss is quite common for Patrick, unfortunate but true. He often forgets that he borrows items and to whom they are to be returned to.

He has not been able to obtain and or hold a suitable job, due to the mental and physical ailments sustained from the accident when he was a young boy. Once again thus adding to the mental anguish of not being able to provide adequately for his family.

Sincerely,

Michelle Wenger
Salt Lake City, Utah
801-577-1258

To: Whom it may concern

Ref: Patrick Owen Barnett

Fr: Scott M. Barnett

My name is Scott M. Barnett, I live in Weber County where I work as a police officer. I am the only brother of Patrick Owen Barnett (plaintiff.)

Pat and I were raised in the same household and I was present during part of the accident that he was injured in when he was about 7 years old. It was May of 1971 and I and my family lived at 252 Chicago St. SLC Utah. I was at home, my mother had driven downtown to pick up my father from work. Someone came to the door and told me that a child had been hit and directed me to the alley. I remember a lot of people gathered around and Pat laying on the street bleeding from his mouth. My sister, Theresa arrived and I ran to find my parents. I found my parents and traveled to the hospital with them. Several months later Pat returned home in a body cast.

Since then I have watched Pat grow up and noticed that he is a very different person than before the accident. While very intelligent, I know that my brother did not pass the 7th grade and has wandered from home to home and job to job. I have watched him be homeless several times and does not appear to be able to obtain or keep a job. I know of only two jobs he has had in the past 39 years and none have lasted more than a few months.

I have talked and talked with him numerous times but, after 39 years it seems that there is more than just a lack of desire or intelligence. I believe my brother has the will to become a valuable member of society but is unable to do so, due to some unknown reason.

Sincerely

Scott M. Barnett 6/24/0

Scott M. Barnett

June 24, 2003

To whom it may concern,

As Patrick Barnett's older sister, I watched him grow up, and took care of him daily. He was an active ~~boy~~, Normal physically and emotionally, With no health problems. Before that tragic day,
I arrived at the accident he was in right behind the ambulance. Neighbors pushed me back, and said not to look, that it was my brother, and the accident was really bad. They did extensive life saving surgery immediately at the hospital. No-one knew if he would be ok, or even live. A few days later Mrs. Brown came to our house in tears, asking for forgiveness, She cried that she didn't even see him. And she felt terrible about running over him. After the Doctors tried to rebuild the broken bones and joints with pins, artificial parts, electric saws, and blood transfusions, he was put in a body cast, After a lengthy stay at the children's Hospital, He was sent home in the body cast. He spent the summer in a hospital bed in our front room. When they took the cast off, he had to learn to walk again. He limped badly when he went back to school, I had to escort him home everyday, so that he would not get beat up by children making fun of his disability. His life changed dramatically after the accident, His memory loss, Physical limitations, Violent nightmares, he gets angry and does not know why, depression and confusion have made it impossible for him to keep a job, and provide for his family. And has made it very difficult to conduct his life, The memory loss I have witnessed for many years has been short term, and long term. He sometimes gets lost driving because of this, and goes through a great deal of pain in his limbs and body.
This is all true and factual to the best of my knowledge.

Theresa Barnett 6-24-03

Theresa Barnett

To whom it may concern,

Pat was a normal healthy little boy, He didnt have any health problems at all, He got along well where ever he went. When Pat was hit, I was getting his father from work, when we got to the hospital, I went in to see Pat, he was gasping for air. I went into the operating room with them and saw them sewing his head in 10 different places. when they started putting the drill through his knee, I passed out. I stayed by his bed every night in the hospital, he woke up screaming 10-12 times every night. and I read a story to him and held his hand till he settled down again. He was in a body cast for one year, and after they took it off, His dad and I had to make him walk back and forth to us, or he would not be walking to this day. He screamed all the time, but we knew he would never walk if we did not do it.
After the accident his looks changed dramatically, and he had; and still has a hard time walking at times because of pain. He cannot remember much of his child hood, and he has been violent at times, he gets too
angry, He had such a hard time trying to remember what was taught to him in school, and could not complete school, He hasent been able to hold down a job for any length of time, or able to take care of his family, for the same reason.
He has fearfull delusional thoughts. Short term and long term memory loss, and gets confused.
He is not the happy, go-lucky young man I remember.

Joyce Barnett 6/25/03

Joyce Barnett (Patricks Mother)

MBER LAKE
.O Box 1041
est Jordan
r 84084
B 10.23.82

PATRICK BARNETT is my uncle. Through my experience with him, he has always been a loving father and has always tried to be the Best provider possible for his family. However I've noticed that hes had to just "Get by" because hes not been able to seek much less hold A job.

He has also complained About Leg. hip & Alot of knee pain ever since I can remember. I've seen various occasions when the use of A cain was needed.

At this time I know he has a pin in his hip and have heard that he will possibly need a hip Replacement.

I have also witnessed some of his spells of temporary memory loss, mostly whe hes outside of his home and forgets directions and where he is to the point of needing to contact someone for help, even when hes just a few blocks from home.

This statement is true and Correct to the best of My knowledge

Amber Carolan